ADN ADMINISTRATORS

VISION CLAIM FORM
Eligibility Verification 1-888-236-1100
MAIL CLAIM FORM TO: ADN
PO BOX 610
SOUTHFIELD, MI 48037

FAX# 1-248-901-3711

EMPLOYER NAME: ROSEVILLE COMMUNITY SCHOOLS – GROUP# 40504

If the employee is paying up front and seeking reimbursement, fill out the form below. Attach detailed receipts and submit for reimbursement to ADN at the address above. Otherwise, supply ADN card to provider for processing.

EMPLOYEE AND PATIENT PORTION

EMPLOYEE'S Social Security Number or ADN Contract ID | EMPLOYEE FIRST & LAST NAME | DATE OF BIRTH

EMPLOYEE'S ADDRESS | PATIENT NAME | PATIENT DATE OF BIRTH

PATIENT'S RELATIONSHIP TO EMPLOYEE
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

OTHER INSURANCE COVERAGE
IS PATIENT COVERED BY ANOTHER VISION PLAN? NO ☐ ADN ☐ OTHER ☐ PROVIDE NAME AND ADDRESS OF OTHER CARRIER

SOCIAL SECURITY NUMBER OR CONTRACT ID OF OTHER INSURED | NAME OF EMPLOYER

OTHER INSURED'S NAME | DATE OF BIRTH

IS THIS CONDITION CAUSED BY EMPLOYMENT? EXPLAIN

DOES CLAIM INVOLVE INJURY? YES ☐ NO ☐
WAS PATIENT INJURED AT WORK? YES ☐ NO ☐
DATE AND TIME OF INJURY_____

SIGNED (EMPLOYEE OR PATIENT) | DATE