VersantHealth™

DavisVision™ SuperiorVision™

# Insurance Frame Replacement Form

FOR OFFICE USE:

| | |
|---|---|
| Patient ID.: | |
| Employee: | |

Last Name: _____ First Name: _____ Date of Birth: ____/_____/____

Address: _____ Apt#: ____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email:_____

Primary Insurance: _____ Insurance Plan: _____ Policy Number:_____

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**Please read and initial the below statements.**

***Initial here**

1. **Your replacement will NOT be ordered unless ALL fields are completed.** x_____
2. You will be notified via text or email once we receive your replacement frames from your insurance company, make sure that we have your correct info on file. x_____
3. Benjamin Optical does not receive updates or have control on turnaround time, **please do not call our store for updates.** The average time is 3 weeks. x_____

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**A.** Reason for replacement: ❑ Lost ❑ Broke

If broken, please describe breakage. _____

**B.** Date of loss/Breakage: ____/_____/____ Date of original sale: ____/_____/____

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1. It is your responsibility to know your own insurance benefits, including your covered benefits and any exclusions in your insurance policy.
2. We will attempt to confirm your coverage prior to service. It is your responsibility to provide accurate information, including any updates or changes.

I hereby authorize Benjamin Optical to submit a claim for a replacement pair of glasses and release all information necessary regarding services rendered to my insurance carrier. I also acknowledge that Benjamin Optical doesn't determine my eligibility or have control on turnaround time.

| Name of Patient / Responsible Party | Signature of Patient / Responsible Party | Relationship to Patient | Date |
|---|---|---|---|

**Benjamin Optical will process your order if eligible within 72 hours of receiving this signed form.**