90 DEGREE BENEFITS
A Turn For The Better
LOUISIANA

SIMPLE
INNOVATIVE BENEFIT PLANS

Vision Claim Form – Submitted by Employee

Employer_____

Group #_____

Employee:_____

Social Security No_____-_____-_____Member ID_____Birth Date_____

Address_____

City_____State_____Zip_____

Phone No_____E-mail_____

Has your address changed since your last claim? ☐ **Yes** ☐ No

Patient Name_____

Relationship to Employee:_____Birth Date: _____

Vision Provider_____

Phone No._____

Address_____

City_____State_____Zip _____

Under penalty of law, I agree to the following:
This claim occurred while the patient was covered by this plan. The attached bill is an original, unaltered bill.

Employee Signature_____Date _____

Please submit an itemized statement complete with the patient's name, provider's name, charges billed.

FOR FASTEST SERVICE PLEASE HAVE YOUR PROVIDER SUBMIT CLAIM ELECTRONICALLY TO:

PAYER ID #72091

YOU MAY ALSO EMAIL, FAX, MAIL or ONLINE THIS FORM AND SUPPORTING DOCUMENTATION TO:

Email: claims.t1@90degreebenefits.com
Fax: 318.747.5074
Mail: 90 Degree Benefits, P. O. Box 71120, Bossier City, LA 71171
Customer Service: 855.502.7223
Register on www.90degreebenefits to submit claims online. Go to Dashboard; then claims; Top of page on left where system states "submit claims/correspondence."