Lifetime
BENEFIT SOLUTIONS
formerly EBS-RMSCO, Inc.

CLAIM FORM
(FOR VISION SERVICES)

EMPLOYER NAME :				
EMPLOYEE NAME : LAST	FIRST	MI	**LIFETIME BENEFIT SOLUTIONS ID # OR SS #:** *(ID # can be found on your ID card)*	
PATIENT'S NAME (IF DIFFERENT FROM ABOVE) : LAST	FIRST	MI	**PATIENT'S DATE OF BIRTH**	
ARE YOU OR ANY OF YOUR DEPENDENTS COVERED UNDER ANOTHER PLAN? ☐ Yes ☐ No			If "YES," please provide the name of the Plan.	
IF YES, NAME OF PLAN:				
REMIT PAYMENT TO: ☐ EMPLOYEE ☐ PROVIDER				

MAKE SURE ALL ENCLOSED BILLS LIST

- DATE(S) OF SERVICE
- ITEMIZED CHARGES ("BALANCE BILL" STATEMENTS CANNOT BE PROCESSED)
- DIAGNOSIS CODE
- NAME OF PROVIDER

EMPLOYEE SIGNATURE _____ DATE _____

Please print and return this form with documentation to the address displayed on the back of your benefit ID card for processing.