
Benchmark Optical**Insurance Information**

Today's date: _____

Last name (patient) _____ First name _____ Middle _____

Primary VISION/OPTICAL Insurance _____

Carrier name _____

Subscriber (card holder) name _____

DOB _____

Social Security # _____

Employer name _____

Contract #/Subscriber ID # _____

Group #/Individual # _____

Relationship to patient _____

Secondary VISION/OPTICAL Insurance _____

Carrier name _____

Subscriber (card holder) name _____

DOB _____

Social Security # _____

Employer name _____

Contract #/Subscriber ID # _____

Group #/Individual # _____

Relationship to patient _____

Primary MEDICAL/HEALTH Insurance _____

Carrier name _____

Subscriber (card holder) name _____

DOB _____

Social Security # _____

Employer name _____

Contract #/Subscriber ID # _____

Group #/Individual # _____

Relationship to patient _____

Secondary MEDICAL/HEALTH Insurance _____

Carrier name _____

Subscriber (card holder) name _____

DOB _____

Social Security # _____

Employer name _____

Contract #/Subscriber ID # _____

Group #/Individual # _____

Relationship to patient _____

Any other possible useful insurance information? _____

I authorize the release of any optical/medical information needed to process all claims and I authorize the release of payment for optical/medical benefits to my optometrist.

Patient or Parent Signature _____ Date _____

I accept that I am fully responsible for any co-pays, deductibles or items not covered by my insurance.

Patient or Parent Signature _____ Date _____