**Signature on File for Insurance Submittals**

I, (print) , hereby authorize Optical Outlook, Jessica Ahmann, OD to use my signature for all insurance claim submittal purposes. This authorization shall end three years from date below.

**I understand this is not a guarantee of payment by my insurance company and that I will be responsible for any balance due.**

 **Insurance Plan/ID#**

Patient signature

 **Insurance Group#**

 / /

Today’s Date **Insurance Co.**

**Patient’s** Address **Insured’s** Name

 Address *if different*

**Patient’s** DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Male □ Female □ **Insured’s** DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Male □ Female □

**Patient** Phone: ( ) **Insured’s** Phone: ( )

**Patient’s** Employer: **Insured’s** Employer:

Relationship to Insured: Marital Status:

**Patient’s** Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insured’s** Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECOND INSURANCE**

**Insurance Plan/ID#**

**Insurance Group#**

**Insurance Co.**

**Insured’s** Name

Address *if different*

**Insured’s** DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Male □ Female □

**Insured’s** Phone: ( )

**Insured’s** Employer:

Marital Status:

**VISION BENEFITS**

**Vision Plan/ID#**

**Vision Group#**

**Vision Co. \_\_\_**

**Insured’s** Name

Address *if different*

**Insured’s** DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Male □ Female □

**Insured’s** Phone: ( )

**Insured’s** Employer:

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_