ALADS Anthem Blue Cross LASIK Benefits

What is LASIK?

Covered services for refractive eye surgeries (LASIK) can be used to correct vision defects like nearsightedness, farsightedness and astigmatism.

What is Covered?

- Lifetime benefit of up to $1,500 per eye for refractive eye surgeries
- Covered refractive eye surgeries include: LASIK, LASEK, LTK, PRK, PARK OR PRK-A
- No referral required from your Primary Care Provider (PCP)
- HMO members must visit an Anthem contracted provider (HMO or PPO) in order for services to be covered
- PPO members have both in-network and out-of-network coverage

How to find an In-Network Provider?

To locate an in-network Ophthalmologist for the ALADS Anthem Blue Cross plans:

1. Visit our Resource link: www.mybenefitchoices.com/alads
2. Under the Provider Search category, choose “Find a HMO Provider/Doctor” or “Find a Prudent Buyer PPO Provider” based on your plan.
    - **HMO members may visit an Anthem contracted HMO or PPO provider**
    - **PPO members may visit an Anthem contracted PPO or HMO provider**
3. Enter your zip code
4. In the search bar, enter “Ophthalmology”
5. **Call to confirm the selected Ophthalmologist provides LASIK services**

Included in your Anthem Blue Cross Medical Plan

For assistance with using your benefits, call the Benefit Service Center at (800) 842-6635

How to file a Claim?

- On Anthem’s claim form (see page 2) list and descibe the services you received (diagnosis, procedure code; and taxpayer ID)
- Include a detailed receipt of services from the provider
- Submit the claim form and detailed receipt via email to aladsclaims@mybenefitchoices.com within 90 days of the date you received the service
    - If you prefer mailing, please contact the Benefit Service Center for mailing instructions
        - Please also complete the Anthem HIPAA authorization form included on pages 3 - 5

Member Claim Form

Anthem Blue Cross

Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing. SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS.

Section A. PATIENT INFORMATION

Last name	First name	M.I.

Does the patient have other health insurance coverage?	Relation to subscriber	Sex	Date of birth (MM/DD/YYYY)
☐ Yes ☐ No	☐ Self ☐ Spouse ☐ Son ☐ Daughter	☐ M ☐ F	

Name of other health insurance company	Group no.	Employer name	Policy no.

Section B. SUBSCRIBER INFORMATION (on Anthem Blue Cross card)

Identification no.	Group no.

Last name	First name	M.I.

Street address (please include apt. no.)

City	State	ZIP code

Home phone no.	Work phone no.	Date of birth (MM/DD/YYYY)
( )	( )	

Section C. MEDICAL INFORMATION

HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Anthem Blue Cross Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) **Attach itemized bill or photocopy**. Please be sure that duplicate bills are not submitted.

Was this medical expense the result of an accident? ☐ Yes ☐ No

Was this condition or injury job related? ☐ Yes ☐ No

Have you filed for Workers' Compensation? ☐ Yes ☐ No

When did this injury or accident occur? (MM/DD/YYYY) ____/____/_____

Diagnosis code	Procedure code	Tax ID

BILLS MUST BE ITEMIZED

Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

- Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Name of patient
- Service provided
- Date of service
- Amount charged for each service
- Diagnosis code
- Procedure code
- Tax ID

I certify that, to the best of my knowledge, the information on this Member Claim Form is true and correct. I authorize the release of any medical information necessary to process this claim.

Signature	Name	Date
X		

Anthem Blue Cross

INDIVIDUAL AUTHORIZATION

Instructions: Please complete the following information exactly as it appears on your member Identification (ID) Card. Complete the form in its entirety and include as much information as possible. If necessary, call the number listed on the back of your member ID card for assistance.

Individual Last Name	*Individual First Name*	*Middle Initial*	*Group ID Number*
Individual ID Number (From Member ID Card)	*Social Security Number (Optional)*	*Date of Birth (mm/dd/yyyy)*	*Daytime Telephone (with Area Code)*
Individual Street Address	*City*	*State*	*Zip Code*

Part A: I authorize the following person or types of people to disclose my information:

Anthem Blue Cross of California and its affiliates and agents

Part B: I authorize the following person or types of people to receive my information (the person receiving the information must be 18 years of age or older):

Benefit Service Center

Relationship to the individual___TPA_____

Part C: I authorize the following information to be used or disclosed on my behalf (check one block):

☐ **All my information** including health (e.g. diagnosis, claims, provider) and financial information (e.g. premium information, checking account) may be disclosed

OR

☐ **Only limited information** may be disclosed (check all applicable blocks below)

Limited Information

- ☐ Appeal
- ☐ Benefits & coverage
- ☐ Billing
- ☐ Claims & payment
- ☐ Diagnosis & procedure
- ☐ Eligibility & enrollment
- ☐ Financial
- ☐ Physician & hospital
- ☐ Pre-certification & pre-authorization
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision

☐ Medical records (excludes psychotherapy notes*)	☐ Pharmacy ☐ Behavioral Health ☐ Other: _____

I do not authorize the release of the following types of sensitive information (check all blocks that apply):

☐ Abortion	☐ Maternity
☐ Abuse (sexual/physical/mental)	☐ Mental health
☐ Alcohol/substance abuse	☐ Sexually transmitted or other communicable diseases
☐ Genetic testing	☐ Other: _____
☐ HIV or AIDS	

Part D: The purpose of my authorization is (check one block):

☐ To disclose the information at my request
☐ For the following purposes: _____

Part E: Expiration Date. If not previously revoked, this authorization will terminate on the earliest of the following dates:

- the date my coverage ends (only if disclosure requested by insurance company); or
- one year from the signature date below; or
- upon the following date, event or condition (within the one year time frame):
  _____

Part F: I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above. I also understand this authorization is voluntary and that the person listed in Part A will not condition my treatment, payment, or enrollment or eligibility for benefits on signing this authorization.

I have the right to revoke this authorization at any time by giving written notice of my revocation to the person listed in Part A. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that information disclosed may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this authorization.

_____ _____

Date **Individual Signature**

Designated Legal Representative / Guardian
If this form is signed by a legal representative / guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf must be attached.
Legal representative (print full name):_____
Legal relationship to individual: _____
Signature: _____ Date: _____

**Note:* *This form cannot be used for psychotherapy notes. If you seek to authorize the use or disclosure of psychotherapy notes, then you will need to do so using a separate form.*

Please keep a copy of this form for your records and return the completed form to:

Benefit Service Center

9500 Topanga Canyon Blvd

Chatsworth, CA 91311