



Innovative Benefits Solutions

Vision Claim Form

Head Office

200 Quikcard Centre p 780.426.7526
17010 103 Avenue f 780.424.7669
Edmonton AB T5S 1K7 1.800.232.1997

Atlantic Canada

201 1600 Bedford Highway p 902.492.2111
Bedford, NS B4A 1E8 f 902.492.2112
1.888.846.4484
quikcard.com

Please Make Payment to:

Provider Cardholder

Patient Information

Quikcard # _____

Name _____ Date of Birth (D/M/Y) _____

Address _____

City _____

Province _____ Postal Code _____

Provider Information

ID # _____

Name _____

Address _____

City _____

Province _____ Postal Code _____

| Date of Service | Procedure | Fee |
|-----------------|-------------------------|-----|
| | 100 Exam | |
| | 110 Glasses | |
| | 120 Contacts | |
| | 130 Clinical Needs | |
| | 140 Optical Supplements | |
| | 150 Low Vision Services | |
| | 160 Other | |

This is an accurate statement of services performed and fees charged

Signature of Provider or Office Designate Date

I declare that the above statements are true and complete to the best of my knowledge and belief.
I understand that fees submitted may be ineligible or exceed plan limits and may not be reimbursed.
I agree that I am financially responsible to my provider for his or her fees.

Signature of Patient, Parent or Guardian Date



Confirmation Number
