Vision

Vision program billing guide

Pennsylvania Blue Shield's vision programs are administered by its wholly-owned subsidiary, Clarity Vision, Inc. They accept both paper and electronic claims.

Claim filing tips and procedures

Participating providers, vision care preferred providers and contracting optical suppliers must submit claims to Clarity Vision for services and products provided to members enrolled in our vision programs.

Please mail paper vision claim forms to:

Clarity Vision, Inc.
PO Box 890500
Camp Hill, Pa. 17089-0500

For information on filing claims electronically — a method we have found to be faster and more economical than paper claims filing — see the information about electronic claims submission on Page 7.

Report vision services only on a vision claim form, form No. 15. Do not use the 1500A claim form. Vision claim forms are provided free of charge.

To obtain vision claim forms, write to or call:

Pennsylvania Blue Shield
Shipping Control Department
PO Box 890089
Camp Hill, Pa. 17089-0089
(717) 763-3256

Or, use the reorder form enclosed with your last shipment of forms.

Here are some helpful tips for submitting your vision claims:

- Type or print all information on the claim form.
- Whenever possible, avoid submitting attachments with your vision claims.
- Complete all information requested. We must have complete information to process the claim. If details are missing, we may need to contact you by telephone or letter, thereby delaying processing and payment of your claim.
- Itemize all services on the vision claim form.
- The date of service reported on the vision claim form should be the date when the member picks up the post-refractive goods. Post-refractive goods should not be held by the provider until payment is received from Clarity Vision.
- Do not report procedure codes 92340-92355 (prescription and fitting of spectacles). You may submit claims for the spectacles you provide, but not for the fitting.
- To report a routine eye exam and refraction, use procedure codes:
  S0620 — Routine ophthalmologic examination including refraction; new patient
  S0621 — Routine ophthalmologic examination including refraction; established patient

  Do not report the procedure codes for general ophthalmologic services (92002, 92004, 92012 or 92014) for a routine eye examination and refraction under our routine vision programs. Report these codes only for ophthalmologic medical examinations.

- The purpose of the eye examination, not the findings, determines the procedure code that should be reported. This also applies to any post-refractive optical products. If a provider identifies a problem during a routine eye exam, or if during the exam the patient indicates a problem or symptom, you should report diagnosis code V72.0 and the appropriate routine eye exam and refraction code.
- When reporting a contact lens evaluation and fitting, use one of these procedure codes:
  Y0060 — Contact lens evaluation, daily wear contacts
  Y0062 — Contact lens evaluation, extended wear contacts
- Do not report procedure codes for contact lens services (92310-92317) for contact lens evaluations and fittings.
- An eye exam and refraction and contact lens evaluation and fitting cannot be reimbursed under an optical supplier's identification number. Only an ophthalmologist or optometrist may report these services.
- When the provider who performs the eye examination and refraction or contact lens evaluation and fitting does not supply the frames or lenses, the provider and the optical supplier must submit separate claims for their respective services.
- If you have questions about completing a claim form, visit our website at **www.clarityvision.com**. You can also contact your Professional Service Vision representative at (717) 972-0498, or the Vision Customer Service department at (717) 760-9680 from 8 a.m. to 6 p.m., Monday through Friday.

Item-by-item guidelines for completing the vision claim form

1. **Patient's Name** — Enter first name, middle initial, if any, and last name. Do not use nicknames.
2. **Patient's Date of Birth** — List the date of birth in month, day, century, year format (MMDDCCYY). Eligibility for benefits is determined by date of birth. Age alone is not acceptable.
3. **Insured's Name** — Enter the first name, middle initial and last name of the person whose name appears on the identification card. It may or may not be the patient. Often, providers and office assistants leave spaces blank when the insured or member and the patient are the same person. However, Pennsylvania Blue Shield cannot assume this to be the case when the space is blank. So, be sure to fill it in with a name or the word “SAME” if the patient and the insured are one and the same person.
4. **Patient's Address** — The address, including street, city, state, ZIP code and telephone number, are important in establishing the identity of the individual.
5. **Patient's Sex** — Self-explanatory.
6. **Insured's ID Number** — This is the most important number needed on the claim form. For Pennsylvania Blue Shield to correctly identify the member's eligibility for benefits, enter this number exactly as it appears on the identification card. Be sure to copy all the numbers and letters (including the alphabetical prefix).
7. **Patient's Relationship to Insured** — This information determines if the patient is covered under the agreement. For example, an employed member may be covered for some benefits, while dependents are not.
8. **Insured's Vision Group Number** — Enter the vision group number exactly as it appears on the identification card. Pennsylvania Blue Shield determines benefits by the group number. Since benefits vary from one group to another, it is vital to report this number.
9. **Other Vision Insurance Coverage** — Indicate the name of the insured, the employer or group, name of the other insurance plan and identification or policy numbers. If there is no other insurance, enter “NONE”; if uncertain, enter “UNKNOWN.”
10. **Was the Service Required As the Result of an Accident?** — Self-explanatory.
11. **Insured’s Address** — This block is for the address of the member, the person with the insurance coverage, not his or her insurance company. Report the complete street, city, state and ZIP code. You may write “SAME” if the address is the same as the patient's.

12. **General Standard** — Complete this block only if lenses or contact lenses were prescribed. Check "YES" if there has been a prescription change of 20 degrees or .5 diopter of sphere power in one eye or combined between both eyes or there is an increase of one line of Snellen acuity (distance or reduced near) from the old prescription to the new prescription. If you check "NO," report the reason for the replacement by checking one of the blocks (1 through 4). This applies to both spectacle lenses and contact lenses. If Number 4 is checked, please explain the reason on the lines provided or attach the medical records.
13. **Contact Lenses** — Complete this block in addition to Block 12 if contact lenses are prescribed. If "YES" is checked for 13A, please explain on the lines provided or attach the medical records.
14. **Frame Replacement Reason** — Complete this block only if new frames are provided. Indicate reason for replacement by checking the appropriate block.
15. **Prescription Date** — Report this date for all post-refractive services.
16. **Diagnosis** — Report the most appropriate three-, four- or five- digit ICD-9-CM diagnosis code. The diagnosis code must refer to the reference number, for example, 1, 2, 3 or 4 in Block 18E under the Diagnosis Code column.
17. **Name of Examining Provider** — Complete this block if the frames, lenses, contact lenses, etc., are supplied by someone other than the provider who performed the vision examination.

18A. **Date of Service or Receipt** — Use numbers for month, day, century and year. The year is important because Clarity Vision will process claims up to one year following the date of service. For post-refractive optical goods, the date of service reported should be the date when the member picks up the post-refractive goods.

18B. **Place of Service** — Office (OF) has been provided for you. If the place of service is other than office, please indicate.

18C. **Procedure Code** — Report the service performed, using the appropriate procedure code from your *Procedure Terminology Manual* (*PTM*). Put a line through services not performed.

18D. **Description of Service** — If you cannot find a code number that describes the procedure(s) you performed, use the appropriate "unlisted procedure" code and describe the service you provided in this area. If a modifier is applicable, enter it in the modifier block. Terminology is unnecessary if the code adequately represents the service. Draw a line through services not rendered.

18E. **Diagnosis Code** — Report the appropriate reference number (1, 2, 3 or 4) from Block 16. Do not report individual diagnosis codes in this block.

18F. **Charges** — Report dollars and cents figures — even if the cents are "00." This assures proper placement of the decimal when the figure is entered into our computer. This should be your total charge for the service(s) reported on that line.

18G. **Days or Units** — Report the number of units. For example, a pair of eyeglass lenses or contact lenses must be reported with a "2" when the procedure code terminology indicates "per lens." A frame should be reported with a "1."

18H. Leave blank.

19. **Signature of Professional Provider or Supplier** — Sign and date the form in this block.
20. **Has Fee Been Paid?** — If partial payment has been made by the member, leave blank.
21. **Total Charge** — Report total charges in dollars and cents — even if the cents are "00." This guarantees correct placement of the decimal during claims processing. This should be the total charge of all services reported on this claim.
22. **Amount Paid** — Do not report partial payments made by members. We calculate the member's liability for each claim. If your claim shows payments exceeding the member's liability, we will pay the member directly. For example, do not report payment differentials made by the member to you for non-standard lenses or for non-covered services. This will ensure that payment is sent to network providers and optical suppliers. Do not report payments by other insurance carriers in this block.

23. **Balance Du**e — Leave blank.
24. **Provider's Social Security Number** — Self-explanatory.
25. **Clarity Vision Provider Number** — Your Pennsylvania Blue Shield assigned provider identification number.
26. **Provider's Employer ID Number** — If you are a professional corporation or professional association, enter your IRS tax identification number here.
27. **Provider's Telephone Number** — Self-explanatory.
28. **Professional Provider or Supplier's Name, Address, ZIP Code and ID Number** — Information in this item may be preprinted on single-sheet claim forms. Preprinted forms are available at no charge from our website, **www.clarityvision.com**, or by calling Shipping Control at (717) 763-3256. If you have forms, which are not preprinted, be sure to provide all of the requested information. If you are not using a preprinted form, the provider's or supplier's name, practicing address (not mailing address), ZIP code and complete provider number must be reported in this block. Report only one provider name and number in the block. A complete provider number consists of two alpha characters plus one to six numeric characters (for example, SM123456). If you do not know your provider number, contact Provider Data Services at (717) 763-3224 from 8 a.m. to 6 p.m., Monday through Friday. Do not report your Medicare UPIN number; it is not applicable to Clarity Vision's claims.

CLARITY VISION
A HIGHMARK COMPANY
P.O. Box 890500
Camp Hill, PA 17089-0500
www.clarityvision.com

VISION CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

PATIENT & INSURED INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*
2. PATIENT'S DATE OF BIRTH (MM/DD/CCYY)
3. INSURED'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(Street, city, state, zip code)*
   TELEPHONE NUMBER ( )
5. PATIENT'S SEX — MALE FEMALE
6. INSURED'S ID NO. *(include any letters)*
7. PATIENT'S RELATIONSHIP TO INSURED — SELF SPOUSE CHILD OTHER
8. INSURED'S VISION GROUP NO.
9. OTHER VISION INSURANCE COVERAGE *(Enter name of policyholder, plan name, address, and policy number)*
10. WAS THE SERVICE REQUIRED AS THE RESULT OF AN ACCIDENT? YES ☐ NO ☐
11. INSURED'S ADDRESS *(Street, city, state, zip code)*

PROFESSIONAL PROVIDER OR SUPPLIER INFORMATION

12. GENERAL STANDARD *(Complete only if lenses were prescribed)*
If lenses were prescribed, was the General Standard met according to the definition below.
YES ☐ NO ☐

General Standard: Change of at least .50 diopter sphere in one eye or combined between both eyes or an increase in one line of Snellen acuity (distance or reduced near).

If no, indicate replacement reason below:

1. ▶ ☐ Lenses replaced due to loss or theft.
2. ▶ ☐ Lenses replaced due to breakage or damage.
3. ▶ ☐ Lenses replaced due to patient preference.
4. ▶ ☐ Lenses replaced due to medically related reasons. Please explain or attach the medical records.

13. CONTACT LENSES *(Complete only if contact lenses were prescribed)*
A. Were contact lenses prescribed as a result of cataract or corneal transplant surgery or other conditions such as keratoconus? (If answer is yes, please explain* or attach the medical records.)
YES 1 ▶ ☐ NO 2 ▶ ☐
B. If A is no, was the vision in the worse eye correctable to a 20/40 or better with regular lenses?
YES 1 ▶ ☐ NO 2 ▶ ☐
C. If B is no, will contact lenses correct the vision in the worse eye to 20/40 or better?
YES 1 ▶ ☐ NO 2 ▶ ☐
*

14. FRAME REPLACEMENT REASON
1. ▶ ☐ Frames replaced due to loss or theft.
2. ▶ ☐ Frames replaced due to breakage or damage.
3. ▶ ☐ Frames replaced due to patient preference.

15. PRESCRIPTION DATE *(month, day, century,year) MM/DD/CCYY*

16. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBER 1, 2, 3, ETC., OR DX CODE.
1. 3.
2. 4.

17. NAME AND ADDRESS OF EXAMINING PROVIDER *(If other than the provider supplying the lenses, frames, etc.)*

18. A DATE OF SERVICE OR RECEIPT (month, day, century, year) MM/DD/CCYY	B PLACE OF SERVICE	C PROCEDURE CODE	D MODIFIER	D PLEASE DATE AND ASSIGN A CHARGE TO THE SERVICES RENDERED. **IMPORTANT! DRAW A LINE THROUGH THOSE SERVICES NOT RENDERED.**	E DIAGNOSIS CODE	F CHARGES	G UNITS	H LEAVE BLANK
	OF	S0620		Routine Eye Exam w/Refraction; New Pt.			1	
	OF	S0621		Routine Eye Exam w/Refraction; Est. Pt.			1	
	OF	Y0060		Contact Lens Evaluation - Daily Wear			1	
	OF	Y0062		Contact Lens Evaluation - Extended Wear			1	
	OF	V2020		Frames			1	

19. SIGNATURE OF PROFESSIONAL PROVIDER OR SUPPLIER *(I certify that I am legally qualified to perform the reported services)*
SIGNED DATE

20. HAS FEE BEEN PAID? YES NO
21. TOTAL CHARGE
22. AMOUNT PAID
23. BALANCE DUE
24. PROVIDER'S SOCIAL SECURITY NO.
25. CLARITY VISION PROVIDER NUMBER
26. PROVIDER'S EMPLOYER ID NO.
27. PROVIDER'S TELEPHONE NO. ( )
28. PROFESSIONAL PROVIDER OR SUPPLIER'S NAME, ADDRESS, ZIP CODE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

15 Q 04/00

INSTRUCTIONS FOR COMPLETING THE VISION CLAIM FORM

PATIENT INFORMATION

1. **Patient's Name** - Enter the name of the patient in first name, middle initial, last name sequence. Use proper name, e.g., Robert versus Bobby.
2. **Patient's Date of Birth** - Enter the patient's date of birth in month, day, century, year sequence.
3. **Insured's Name** - Enter the name of the person whose name appears on the identification card in first name, middle initial, and last name sequence. If the insured is the same as the patient, "SAME" will suffice.
4. **Patient's Address** - Enter the street address, city, state, zip code, and telephone number.
5. **Patient's Sex** - Self-explanatory.
6. **Insured's ID No.** - Copy from the patient's identification card, including any letters. Depending on the member's (your patient's) employer, the member may present an ID card with a Highmark Blue Cross Blue Shield logo, Pennsylvania Blue Shield logo, or a Clarity Vision logo.
7. **Patient's Relationship to Insured** - Indicate the relationship of the patient to the insured by checking the appropriate box.
8. **Insured's Vision Group Number** - Enter the vision group number as it appears on the identification card.
9. **Other Vision Insurance Coverage** - Indicate whether patient has other **vision insurance**, policyholder name, the name and address of the carrier, and policy number. If there is no other insurance, enter "NONE;" if uncertain, enter "UNKNOWN."
10. **Was the service required as the result of an accident** - Self-explanatory.
11. **Insured's Address** - Enter the street address, city, state, and zip code. If the insured's address is the same as the patient, "SAME" will suffice.

PROVIDER OR SUPPLIER INFORMATION

12. **General Standard** - (This is a required block.) - Indicate whether or not the standard has been met by checking the appropriate box. If standard has not been met, indicate replacement reason by checking the appropriate box.
13. **Contact Lenses** - (Complete only if contact lenses were prescribed.) - Indicate whether or not the lenses were supplied as a result of eye surgery or other condition. If contact lenses were supplied as a result of these conditions, give an explanation on the line provided or attach medical records.
14. **Frame Replacement Reason** - (Complete only if new frames are provided.) - Indicate reason for frame replacement by checking the appropriate box.
15. **Prescription Date** - Date prescription was issued to the patient.
16. **Diagnosis or Nature of Illness or Injury** - Report the most appropriate 3-, 4-, or 5-digit ICD-9-CM diagnosis code. The diagnosis code must refer back to the reference number, for example, 1, 2, 3, or 4 in Block 18E in the diagnosis code field.
17. **Name and Address of Examining Provider** - Professional Provider performing the vision examination (if other than the provider of the frames, lenses, contact lenses, etc.).
18. **Specific Claim Information** - Indicate A) date the service was provided, or date the lenses, frames, contacts, etc. were dispensed to the patient, B) place of service (if other than office, please indicate), C) procedure code, D) procedure code modifier (if applicable), explanation or description of services, E) diagnosis code, F) charge for the service. Report charges in dollars and cents - even if the cents are "00," G) number of services, and H) leave blank. ***IMPORTANT! PLEASE PUT A LINE THROUGH SERVICE(S) NOT RENDERED.**
19. **Signature of Professional Provider or Supplier** - Sign and date the form in this block.
20. **Has Fee Been Paid** - If partial payment has been made by the member, leave blank.
21. **Total Charge** - Report total charges on this claim form in dollars and cents - even if the cents are "00."
22. **Amount Paid** - Do not report partial payments made by members. We calculate the member's liability for each claim. If the claim shows payments exceeding the member's liability, we will pay the member directly, not the Participating Provider, Preferred Provider, or Contracting Optical Supplier. For example, do not report payment differentials made by the member for non-standard lenses or for non-covered services. This will ensure that payments are sent to network providers and optical suppliers.
23. **Balance Due** - Leave blank.
24. **Provider's Social Security Number**
25. **Clarity Vision Provider Number** - Include two alpha prefix.
26. **Provider's Employer ID Number**
27. **Provider's Telephone Number**
28. **Professional Provider or Supplier's Name** - Indicate name, address, and zip code.

Modifier	Description
VP	Aphakic patient
WV	Cosmetic contact lens
YK	Standard glass lens
YM	Non-standard glass lens
YQ	Non-standard plastic lens
YX	Double bifocal lens
ZX	Prescription on file for AR, UV, tint, or oversized lens (SecurityBlue post-cataract)
52	Reduced services (used to report a sale or discount)

Get the facts . . . through ClariFax℠

ClariFax allows you to obtain information via your touch-tone telephone and your fax machine. You simply call, enter your patient's identification number, and the benefits and patient information you need are automatically faxed to you within minutes.

Call (800) 746-5682 now to become authorized to use ClariFax.

If you have questions concerning ClariFax, call your Clarity Vision Vision Professional Service Representative at the number listed below or visit our website at **www.clarityvision.com**.

To contact your Clarity Vision Professional Service Representative, call (717) 972-0498, outside Pennsylvania call (800) 541-2039.

Clarity Vision, Inc. is a for-profit, wholly-owned subsidiary of Highmark Inc. Clarity Vision is the administrator of Highmark's vision programs. Highmark was created by the consolidation of Pennsylvania Blue Shield and Blue Cross of Western Pennsylvania.

Electronic claims submission

Medical billing systems

If you are currently billing medical-surgical services to Pennsylvania Blue Shield, you can now bill your vision claims through the same process. If you are not yet enjoying the benefits of electronic billing, or need to obtain authorization, please contact your Clarity Vision Professional Service representative at (717) 972-0498 or Highmark EDI Services at (800) 992-0246 for information on how to get started.

Contact your vendor to add Pennsylvania Blue Shield - VISION as a unique insurance carrier to your patient file database.

General standards

For vision program members whose benefits require that the general standards provisions be met, enter "General Standards Met" in the narrative field of your claim entry screen, if in fact the general standards were met.

Please contact your vendor if you are uncertain as to whether the narrative field has been programmed for your use.

National Standard Format, Version 200

Narrative record
Record – HA0
Field number – 05
Positions – 40-320

ANSI ASC X12 837, Version 30.51

Additional documentation
NTE segment – 2-485
Data element – 02-03

Your vendor may be able to enhance or support an alternative method for you to enter and transmit the general standards information. Please contact your vendor for assistance.

Submitting vision claims over the Internet

Submit your Clarity Vision claims to us over the Internet. Our online service, requiring only a browser (Netscape® 4.5 or higher or Microsoft® Internet Explorer 4.0 or higher), allows you to submit claims through our website at **www.clarityvision.com**.

Claims completion instructions are included on our site along with a "Help" and a security feature that keeps unauthorized users from accessing the site and protects confidential patient and provider information. Online claims submission offers many benefits, including cost savings on postage, time savings on claims corrections and quicker payment.

You must be a participating provider or a vision care preferred provider or contracting optical supplier and have a provider number to use the free service. Visit our provider services page on our website at **www.clarityvision.com/provider/provider.html**. Under "Online Claims Submissions," click on the link, "Request authorization for online claim submission here." Complete all information on the Claims Submission Request form and click the "Submit Request" button. You will be notified of your approval to submit claims online.

Sources of information

Clarity Vision's website, www.clarityvision.com

Clarity Vision offers valuable vision information and services on its website. A section of the site is tailored specifically to meet the needs of vision providers. Among other interesting topics, here are more features in our Provider Services section:

- Online Claims Submissions
- Frequently asked questions (FAQs)
- *A Closer Look* and *Vision News* library
- OptiChoice interactive reimbursement worksheet that allows you to calculate your patients' liability
- Claims submission and billing guide
- Procedure codes and modifiers
- ClariFax information
- Electronic billing information
- Provider directory
- Professional Service representatives' territories

Clarity Vision's website also links to a variety of professional resources such as:

- American Academy of Ophthalmology
- American Academy of Optometry
- American Society of Cataracts and Refractive Surgery
- *Optometry Today*
- *Vision Monday*

Please see Clarity Vision's Other Related Sites page for a complete listing.

ClariFax

ClariFax is a way to obtain vision information that is easy, fast and free. ClariFax allows you access to vision benefits, eligibility, service restrictions and claims status information through your touch-tone telephone and fax machine.

You make the toll-free call and then receive the information through your fax machine. Within minutes, ClariFax can provide information for patients enrolled in Blue Shield's vision programs.

Call ClariFax at (800) 746-5682. Select the option you desire from our list of features and ClariFax will do the rest.

ClariFax is available:

Monday – Friday, 7 a.m. to 11 p.m.
Saturday and Sunday, 7 a.m. to 5 p.m.

Call (800) 746-5682 to become authorized to use ClariFax. We will fax an authorization form for you to complete and fax back to us. We will notify you of your authorization to use ClariFax.

If you have any questions about ClariFax, visit our website at **www.clarityvision.com** or contact your Vision Professional Service representative at (717) 972-0498.

CareConnect

CareConnect now offers allowance information for patients enrolled in Pennsylvania Blue Shield's vision programs. The CareConnect network brings up-to-the-minute member data to your office computer.

You can access a patient's benefits, claim status, eligibility and allowance information. To best serve you, the network is available when you are.

To access the vision allowances, once you are logged into CareConnect:

- Select No. 8 (Clarity Vision) from the health care payers menu.
- Select No. 2 (Vision Inquiry) from the Clarity Vision menu.
- Select No. 1 (Benefits) from the vision inquiry menu.

Select the appropriate examination and post-refractive services categories for the allowances in question.

For example, to view lens allowance information for a patient, select No. 5 (lenses) from the vision benefits screen.

To obtain access to CareConnect, contact your Clarity Vision Professional Service representative at (717) 972-0498, or Highmark EDI Services at (800) 992-0246.

A Closer Look

A Closer Look, Clarity Vision's vision provider newsletter, is published quarterly. The newsletter is designed to inform providers and their office staff of:

- new vision programs or changes to existing ones.
- changes in existing vision medical policy or the adoption of new vision policies.
- billing procedures and coding information.
- tips for accelerating the claims payment process.
- revisions to the *PTM*.

A Closer Look has:

- a table of contents.
- an index in each February issue listing all articles published the previous year.
- the ability to be stored in a three ring binder — it's three-hole punched.
- a provider change of information coupon in two issues each year.
- an online version at **www.clarityvision.com/provider/news_index.html**.

If you have comments or questions about *A Closer Look*, please call your Clarity Vision Professional Service representative at (717) 972-0498.

Clarity Vision Professional Service representatives

Visit Clarity Vision's website at **www.clarityvision.com/provider/provider_reps.html** for a complete listing of the Vision Professional Service representatives and their respective territories. Or, call (717) 972-0489.

For information on how to join our vision provider networks, please call your Clarity Vision Professional Service representative.

Here is a directory of Clarity Vision's Professional Service representatives, their telephone and fax numbers and the territories they serve:

Representative	Territory (County/ZIP codes)
Paula DeSousa Voice: (717) 972-0498 Fax: (717) 730-1180	Bradford, Bucks, Carbon, Clinton, Columbia, Lackawanna, Lehigh, Luzerne, Lycoming, Monroe, Montour, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne and Wyoming counties Montgomery County ZIP codes: 18041, 18054, 18070, 18073, 18074, 18076, 18915, 18936, 18964, 18969, 19001, 19002, 19006, 19012, 19025, 19027, 19031, 19034, 19038, 19040, 19044, 19046, 19075, 19090, 19095, 19111, 19117, 19118, 19401, 19403 - 19406, 19422, 19426, 19435, 19436, 19438, 19440, 19444, 19446, 19453, 19454, 19462, 19464, 19468, 19473, 19474, 19477, 19465, 19492, 19504, 19525 Philadelphia County Zip codes: 19111, 19114 - 19116, 19119, 19120, 19124, 19126, 19127, 19128, 19135 - 19138, 19141, 19144, 19149, 19150, 19152, 19154
GeriAnn Heffren Voice: (717) 972-0498 Fax: (717) 730-1180	Adams, Berks, Chester, Cumberland, Dauphin, Delaware, Franklin, Fulton, Juniata, Lancaster, Lebanon, Mifflin, Northumberland, Perry, Snyder, Union and York counties Centre County except ZIP codes: 16829, 16859, 16866, 16874 Montgomery County Zip codes: 19003, 19004, 19010, 19035, 19041, 19066, 19072, 19096,19428 Philadelphia County Zip codes: 19102 - 19107, 19109, 19112, 19113, 19118, 19121 - 19123, 19125, 19129 - 19134, 19136, 19139, 19140, 19142, 19143, 19145 - 19148, 19151, 19153
Kathleen McCann Voice: (412) 544-2347 Fax: (412) 544-2380	Beaver, Butler, Clarion, Crawford, Erie, Greene, Lawrence, McKean, Mercer, Venango, Warren and Washington counties. Allegheny County ZIP codes: 15017, 15021, 15026, 15056, 15064, 15071, 15082, 15106, 15108, 15126, 15136, 15142, 15143, 15201, 15204, 15205, 15206, 15208, 15212, 15213, 15217, 15218, 15219, 15220, 15221, 15222, 15224, 15225, 15230, 15232, 15233, 15240, 15242, 15244, 15260, 15261, 15264, 15267, 15275, 15282
MaryAnn Westfall Voice: (412) 544-2349 Fax: (412) 544-2380	Armstrong, Bedford, Blair, Cambria, Cameron, Centre (16829, 16859, 16866 and 16874), Clearfield, Elk, Fayette, Forest, Huntingdon, Indiana, Jefferson, Potter, Somerset and Westmoreland counties. Allegheny County ZIP codes: 15007, 15014, 15015, 15018, 15024, 15025, 15030, 15034, 15035, 15037, 15039, 15044, 15045, 15046, 15047, 15049, 15065, 15076, 15084, 15086, 15088, 15090, 15101, 15102, 15104, 15110, 15112, 15116, 15120, 15122, 15123, 15127, 15129, 15131, 15132, 15133, 15134, 15135, 15137, 15139, 15140, 15144, 15145, 15146, 15147, 15148, 15202, 15203, 15207, 15209, 15210, 15211, 15214, 15215, 15216, 15223, 15226, 15227, 15228, 15229, 15234, 15235, 15236, 15237, 15238, 15239, 15241, 15243

Mailing addresses

Vision claims submission

Pennsylvania Blue Shield vision claims:
Clarity Vision, Inc.
PO Box 890500
Camp Hill, Pa. 17089-0500

Written inquiries

Clarity Vision, Inc.
PO Box 890035
Camp Hill, Pa. 17089-0035

Selected telephone numbers

ClariFax (800) 746-5682

Clarity Vision customer service (717) 760-9680 (For information not provided by ClariFax)

Clarity Vision Professional Service representative (717) 972-0498 (For information on how to join our vision provider networks)

Vision programs and coverage

Pennvision

Clarity Vision offers various benefit coverages under Pennvision, Pennvision II, Options 1 and 2, and Pennvision III. Pennvision programs use the participating provider network.

Pennvision II programs are a combination of UCR and indemnity schedule of payments.

- The eye examination and refraction are paid using the UCR method, and the post-refractive services are paid according to an indemnity schedule of allowances.
- Participating providers agree to accept the UCR payment for the eye examination and refraction as payment in full.
- Participating providers may bill the Pennvision member the difference between the indemnity schedule of allowances for post-refractive services and their charges.

Payment will be made on the basis of the following indemnity schedule of allowances or the amount charged — whichever is less — and will constitute final discharge of Clarity Vision's responsibility under the program.

	Option 1	Option 2
Frame	$18	$24
Lenses (pair)		
Single vision	$18	$24
Bifocal	$27	$36
Trifocal	$35	$46
Aphakic	$55	$72
Contact lenses (pair)		
Hard	$36	$48
Soft	$36	$48

Pennvision III

Some customer groups request variations in coverage to our Pennvision program to meet their own specific vision care needs. In these instances, coverage may vary from our standard Option 1 or Option 2 programs. For example:

- The eye examination and refraction may be paid at an indemnity allowance instead of the UCR; or,
- The indemnity allowance for post-refractive services may be higher or lower than the Option 1 or Option 2 program indemnity allowance.

Standard benefit periods

- Group members under 19 years of age are eligible for an eye examination and refraction, and eyeglass lenses or contact lenses once in any 12-month period.
- Those 19 years of age and older are eligible once in any 24-month period.
- Frames are eligible once in any 24-month period regardless of age.
- Payment will not be made for both a complete set of eyeglasses and contact lenses within a 24-month period.

OptiChoice®

OptiChoice is a vision preferred provider program that provides coverage for:

- Eye examinations and refractions;
- Contact lens evaluations and fittings; and
- Post-refractive optical goods

OptiChoice utilizes the Vision Care Preferred Provider and Contracting Optical Supplier network.

Standard program benefits are:

Covered products/ professional services	**Program allowance accepted as full payment by preferred providers/ contracting suppliers**	**Comments**	**Frequency/ age limits** (see Page 14)
Eye examination and refraction	$32	Use procedure code S0620 — Routine ophthalmologic examination including refraction; new patient or S0621 — Routine ophthalmologic examination including refraction; established patient.	A*
Contact lens evaluation and fitting			
▪ Daily wear contacts	$20	Use procedure code Y0060, contact lens evaluation/fitting — daily.	A*
▪ Extended wear contacts	$30	Use procedure code Y0062, contact lens evaluation/fitting — extended.	

** Only ophthalmologists and optometrists may report these services.*

Covered products/ professional services	Program allowance accepted as full payment by preferred providers/ contracting suppliers	Comments	Frequency/ age limits (see Page 14)
Frame	$24	Use these procedure codes: V2020 — Frames, purchases (including athletic frames) Y9784 — Frames for sunglasses Y0110 — Frames, safety. Covers all frames with selling price equal to or less than $60. Member is responsible for the difference between $60 and the selling price of any frame over $60.	B
Eyeglass lenses (pair) ▪ Single vision ▪ Bifocal ▪ Trifocal ▪ Aphakic/lenticular	 $24 $36 $46 $72	Covers standard prescription lenses of all sizes and powers. Standard eyeglass lenses are glass or plastic lenses of all sizes and dioptric powers with no special features or material applied during or after the manufacturing process. For specialty lenses, the member is required to pay 90 percent of the difference between the provider's charge for specialty lenses and the charge for standard lenses. Specialty lenses include, but are not limited to, progressives, polycarbonate, balance, photochromatic, prism, occluder and special base curves.	A
Contact lenses (pair) ▪ Hard daily wear spherical ▪ Soft daily wear spherical ▪ Specialty contact lenses (for example, extended wear, gas permeable, toric, disposable,* and bifocal)	 $48 $48 $48	 Covers specialty contact lenses selling for $75 or less. Member is responsible for difference between $75 and the selling price of any pair of specialty contacts over $75/pair.	 A
Vision care options Includes such lens options as scratch resistant coating, UV coating, AR coating, eyeglass tints and fashion tints for contacts. Includes supply options such as contact lens solutions, sunglasses and other optical supplies.		Ten percent discount below selling price extended by provider or supplier (if member pays for options at point of purchase). This 10 percent discount is in addition to and not in lieu of any other special promotions and/or sale prices.	C

** Two boxes equals one pair.*

Frequency/age limitations (the chart on Pages 12 - 13 shows the standard age and frequency limitations, groups have the option to select different age and frequency options):

A — Covered once every 24 months for members 19 years of age or older, and once every 12 months for members under age 19.
B — One frame covered once every 24 months for all members. Frames for prescription sunglasses, prescription safety glasses, or frames for prescription athletic glasses can be purchased in lieu of frames for regular glasses.
C — No limitation on frequency or age for these products. Pennsylvania Blue Shield does not pay for these items.

Although the standard program benefits chart shows the standard OptiChoice age and frequency limitations, groups have the option to select different age and frequency options for their members.

In addition to the options above, OptiChoice In-network Only and Voluntary OptiChoice programs are available.

- OptiChoice In-network Only provides coverage that limits benefits to services provided by preferred providers and contracting optical suppliers.
- Voluntary OptiChoice is a vision program with the same benefits as traditional OptiChoice except Voluntary OptiChoice has an annual benefit period regardless of age.

Plus, individuals and families have the option to purchase OptiChoice directly from us.

Additional eyewear benefits

The OptiChoice program is unique in that it allows members to obtain eye examinations and refractions, contact lens evaluations and fittings, and post-refractive products at the program allowances, no matter how many times a member wishes to purchase them. However, the member must pay the preferred provider or contracting supplier directly for the products at the point of purchase. To assist you in determining the member's responsibility, an interactive OptiChoice worksheet is available at **www.clarityvision.com/provider/opt.html**.

Specials and sales

Any special prices and sales offered to other consumers should be offered to OptiChoice members in the event that a provider's sale price is a better financial alternative than the member's benefits based upon full retail value. Preferred providers and contracting optical suppliers must submit these services to Clarity Vision. We will reimburse the member up to the program allowances. These conditions must be met:

1. Document in your records how the sale was a better financial alternative for the member.
2. Write the word “sale” or “discount” on the claim form.
3. Box 20 (Has fee been paid?) on the Clarity Vision claim form must be marked “yes.”
4. Box 21 (Total charge) and 22 (Amount paid) on the Clarity Vision claim form must be the same amount.
5. Collect the sale amount from your patient at the point of purchase.
6. If using the HCFA 1500 form to submit services, Box 28 (Total charge) and 29 (Amount paid) should be the same amount.

Your Explanation of Benefits (EOB) will indicate that a sale was used and that you are not required to accept the program allowances as payment in full.

Attention electronic billers and users of Internet claims submission:

Submit a 52 modifier along with your normal procedure codes to indicate that a sale was used. However, only use the 52 modifier when you have collected or are billing the member for your entire charge.

VueFlex℠

VueFlex is a vision care program with flexible benefit and reimbursement options.

- Various benefit plan designs are offered with different levels of in- and out-of-network coverage.
- Each customer group selects a level of benefits to meet its particular needs.
- The program covers eye examinations and refractions, contact lens evaluations and fittings and post-refractive optical goods, that is, lenses, frames, vision care options and vision accessories.
- VueFlex utilizes the Vision Care Preferred Provider and Contracting Optical Supplier network.

Program benefits and reimbursement

Under the standard program, members of all ages are eligible for benefits once every two calendar years beginning Jan. 1 prior to the first incurred service paid under the program. For example, if the first claim submitted for a patient was for a service rendered on May 1, 2000, the member's two-year benefit period would be from Jan.1, 2000, through Dec. 31, 2001.

Program allowances are as follows:

Eye examination and refraction	$32
Contact lens evaluation and fitting	
▪ Daily wear	$20
▪ Extended wear	$30
Post-refractive products	$35 to $200

Preferred providers agree to accept the program allowances for eye examinations and refractions and contact lens evaluations and fittings as payment in full.

The reimbursement for post-refractive optical goods is a maximum indemnity program allowance. The member can use the VueFlex program allowance toward eyeglasses, contact lenses, options (such as, but not limited to, tints, special coatings, lens care supplies, safety glasses, non-prescription sunglasses), and optical accessories (such as, but not limited to eyeglass cases, eyeglass straps). If the member purchases optical goods that exceed his or her program maximum indemnity allowance, he or she is responsible for any charges in excess of this allowance.

Gateway Health Plan Vision

Gateway Health Plan is a partnership of Pennsylvania Blue Shield and Mercy Health Plan of Philadelphia.

- Members of this program carry a Gateway Health Plan identification card, which references their medical, dental and vision benefits.
- The Gateway Health Plan vision program uses the Vision Care Preferred Provider and Contracting Optical Supplier network, which supports the OptiChoice/VueFlex℠ vision programs.

Clarity Vision administers the vision program offered through Gateway Health Plan to Medical Assistance recipients residing in Allegheny, Armstrong, Beaver, Berks, Blair, Butler, Cambria, Clarion, Cumberland, Dauphin, Erie, Fayette, Greene, Indiana, Jefferson, Lawrence, Lehigh, Mercer, Montour, Northumberland, Schuylkill, Somerset, Washington or Westmoreland counties.

HealthChoices Gateway Health Plan counties

HealthChoices is a mandatory managed care program for Pennsylvania Medical Assistance recipients in Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington or Westmoreland counties.

Providers practicing in these counties must have a Medical Assistance identification (MAID) number from the Pennsylvania Department of Public Welfare in order to provide routine vision care services to Gateway Health Plan members.

Receiving vision services

Members have an in-network only program. For vision services to be covered, members must obtain services from a vision care preferred provider or contracting optical supplier who has a Medical Assistance identification number (MAID).

Reporting services

Providers who usually report services under their Blue Shield assignment account identification number must also report the individual provider identification number of the provider who performed the service on claims for Gateway Health Plan members.

For those providers who are not members of an assignment account, please bill under your individual Blue Shield provider identification number.

Obtaining a MAID number:

Contact the Pennsylvania Department of Public Welfare at this address or phone number to apply for a MAID number:

Pennsylvania Department of Public Welfare
Provider Enrollment Unit
PO Box 8045
Harrisburg, Pa. 17105-2675
(717) 772-6140 (Monday through Friday, 8:30 a.m. to Noon)
(717) 772-6456 (For requesting enrollment applications only)

When a provider receives (or if they already have) a MAID number, he or she should notify Clarity Vision of the number to ensure that services for Gateway Health Plan members process correctly. The individual Pennsylvania Blue Shield provider identification number should be included with the MAID number when submitting information to Clarity Vision. This information can be submitted through the mail or fax at:

Clarity Vision, Inc.
Professional Service
PO Box 890089
Camp Hill, Pa. 17089-0089
Fax: (717) 730-1180

Non-HealthChoices Gateway Health Plan counties

Providers practicing in Berks, Blair, Cambria, Clarion, Cumberland, Dauphin, Erie, Jefferson, Lehigh, Mercer, Montour, Northumberland, Schuylkill or Somerset counties do not need a MAID number to provide routine vision care services to Gateway Health Plan members.

Reporting services

When reporting services, providers may use either their assignment account or their individual Pennsylvania Blue Shield provider identification number.

Statewide benefits

Here are the benefits and associated information for the entire Gateway Health Plan service area:

Members under 21 years of age (group No. 080373-001, group No. 080373-003) are covered under a modified VueFlex in-network only program. The benefits are:

1. One eye examination and refraction per calendar year, paid at the VueFlex allowance of $32. Members may be eligible for additional eye examinations if medically necessary.
2. One contact lens evaluation and fitting per calendar year, paid at the VueFlex allowances of $20 for daily wear and $30 for extended wear contact lenses.
3. A $125 combined calendar year allowance for prescription eyeglasses, prescription sunglasses, prescription safety glasses and prescription contact lenses. Cosmetic tints on contact lenses are not covered. The benefit for prescription contact lenses includes daily wear and specialty lenses. Members may be eligible for additional post-refractive benefits if medically necessary.

Members age 21 and older (group No. 080373-000, group No. 080373-002) are covered under a standard OptiChoice in-network only program. The benefits are:

1. One eye examination and refraction per calendar year, paid at the OptiChoice allowance of $32.
2. One contact lens evaluation and fitting per calendar year, paid at the OptiChoice allowances of $20 for daily wear and $30 for extended wear contact lenses.
3. One pair eyeglasses or contact lenses per calendar year, paid at OptiChoice allowances.
4. Standard OptiChoice discounts and additional eyewear benefits apply.

Member identification number

The identification number listed on a Gateway member's card is a six- or eight-digit number and should be used when communicating directly with Gateway Health Plan.

However, when communicating with Clarity Vision for claim submissions, inquiries or benefit information, please include the letter “G” as the first character or the letter/number combination “G00” as the first characters in the Gateway member's nine-character identification number.

For example, if the member's number is “12345678,” you would add the “G” to create G12345678. If the member's number is “123456,” you would add “G00” to create G00123456.

Bethlehem Steel, Transtar and USX Vision

Bethlehem Steel, Transtar and USX use the Vision Care Preferred Provider and Contracting Optical Supplier network. Members of these plans should present a Pennsylvania Blue Shield vision program card.

Contact lens evaluation and fitting is not a covered benefit under this plan. Providers may bill the members their charge for a contact lens evaluation and fitting. One pair of prescription eyeglasses (frames and lenses) or one pair of contacts is eligible within a benefit period.

The following benefits are available for all members and eligible dependents.

Professional services	Frequency	Program allowances
Eye exam and refraction	One per 24 months	$35
Preferred providers accept this allowance as payment in full.		

Post-refractive products	Frequency	Program allowances
Frames (up to a $100 retail value)	One pair per 24 months	$64
Preferred providers accept the $64 program allowance as payment in full for frames that retail for $100 or less. Members are responsible for any amount over $100.		
Single vision lenses (standard)	One pair per 24 months	$50*
Bifocal lenses (standard)	One pair per 24 months	$60*
Trifocal lenses (standard)	One pair per 24 months	$70*
Aphakic/lenticular lenses (standard)	One pair per 24 months	$80*
Contact lenses	One pair per 24 months	$70**
Disposable contact lenses are paid up to $70 maximum regardless of the number of boxes (pairs) purchased.		

Vision care options		
Such as, but not limited to: tints, UV coating, scratch coating and contact lens solutions	No program allowance	Preferred providers give a 10 percent discount on vision care options

Certain Transtar groups use preferred provider network

Since Oct. 1, 1998, members of Transtar groups 54145-00, 54145-05, 54145-06, 54145-70, 54145-75 and 54145-76 have used the preferred provider network. Members of these plans should present a Pennsylvania Blue Shield vision program card.

Contact lens evaluation and fitting is not a covered benefit under this plan. Providers may bill the members their charge for a contact lens evaluation and fitting. One pair of prescription eyeglasses (frames and lenses) or one pair of contacts is eligible within a benefit period.

The following benefits are available for all members and eligible dependents.

Note: Some Transtar members utilizing the preferred provider network have standard OptiChoice benefits.

Professional services	Frequency	Program allowances
Eye exam and refraction	One per 24 months	$32
Preferred providers accept this allowance as payment in full.		

* *Preferred providers accept the specified program allowance as payment in full for standard lenses. The allowance for non-standard lenses, such as, but not limited to, polycarbonate, high-index, transitions or progressive lenses, is the same as for standard lenses. The member is responsible for the difference between the provider's charge for standard lenses and non-standard lenses, minus a 10 percent discount.*

** *Preferred providers may balance bill the member to their charge.*

Post-refractive products	Frequency	Program allowances
Frames (varies per group number)		
Group number 54145-06 and 54145-76	One pair per 24 months	$64 Accepted as payment in full for frames that retail for $100 or less.
Group numbers 54145-00, 54145-05, 54145-70, 5414-75	One pair per 24 months	$24 Accepted as payment in full for frames that retail for $50 or less.
Single vision lenses (standard)	One pair per 24 months	$24*
Bifocal lenses (standard)	One pair per 24 months	$36*
Trifocal lenses (standard)	One pair per 24 months	$46*
Aphakic/lenticular lenses (standard)	One pair per 24 months	$72*
Contact lenses	One pair per 24 months	$50**
Disposable contact lenses are paid up to $50 maximum regardless of the number of boxes (pairs) purchased.		
Vision care options		
Such as, but not limited to: tints, UV coating, scratch coating, and contact lens solutions	No program allowance	Provider's charge minus 10 percent

Bethlehem Steel, Transtar and USX members' vision program benefits history will be considered in determining if the frequency limitation has been met. If a member has received an eye exam, eyeglasses or contact lens in the past 24 months, he or she will not be eligible again for the similar service until 24 months from the date of service.

ALCOA vision plans

Eligible members enrolled in these plans will present a Pennsylvania Blue Shield identification card that states "ALCOA Vision Plan."

General plan information

- Routine eye examinations and refractions (S0620 or S0621) and/or contact lens evaluations and fittings (Y0060 or Y0062) are reimbursed only when performed by an optometrist or an ophthalmologist.
- Frequency is the same regardless of age.
- Allowances are per pair for either one pair of eyeglass lenses or one pair of contact lenses within a benefit period.
- Medically necessary contact lenses are defined as contact lenses prescribed after cataract surgery, corneal transplant surgery, or other conditions such as, but not limited to, keratoconus if indicated, or when visual acuity is not correctable to 20/40 in the worse eye by use of lenses in a frame but can be improved to 20/40 or better by the use of contact lenses.

* *Preferred providers accept the specified program allowance as payment in full for standard lenses. The allowance for non-standard lenses, such as, but not limited to, polycarbonate, high-index, transitions, or progressive lenses, is the same as for standard lenses. The member is responsible for the difference between the provider's charge for standard lenses and non-standard lenses, minus a 10 percent discount.*

** *Preferred providers may balance bill the member to their charge.*

- A special general standard provision applies that allows for an additional pair of either eyeglass lenses or contact lenses within the benefit period. General standards are met if there is a prescription change of .50 diopter in either eyeglass lenses or contact lenses. The general standard must be met for a different date of service from the previous exam. When submitting claims, be sure to check the appropriate boxes on the Clarity Vision claim form or write “General standards have been met” on the HCFA 1500 claim form.
- Preferred and participating providers are obligated to submit vision claim forms for professional services and post-refractive products rendered to members.
- If your sale price is financially a better offer than the member's benefits based upon full retail, you should collect your sale price from the member. Submit a claim to us, note “sale” or “special price,” indicate a fee was paid, and report the total amount paid. We will reimburse the member up to the program allowances.

  Note: When checking benefits, ClariFax will not show dependents for the ALCOA network, ALCOA/ St. Louis Foils or ALCOA/Kawneer plans.

Please periodically check our website at **www.clarityvision.com/provider/alcoa.html** for specific vision benefits and for new and updated information for the ALCOA vision plans.