

# Coordination of Benefits (COB) for Exams Between Health Plans or Medicare and VSP® Vision Care



Claims for coordination of benefits between health plans or Medicare and VSP for exams can now be submitted electronically through eClaim on **eyefinity.com**.

Begin your claim as you normally would and follow these steps.

## 1. Make it match

Provide the same diagnosis, exam, and refraction codes from the primary claim.

\* 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.  
(RELATE ITEMS A-L TO ITEM 24E (DIAGNOSIS) BY LINE)

ShowHCPCS/CPT Descriptions

	A	B	C	D	E	F	G	H	I	J	K	L
24a	Z01.00											
* FROM												
* TO												
POS	11											
EMG												
*24d PROC	V2762											
MODS												
*24e DIAGNOSIS	A											
* CH	\$ 10											
1	07/20/2015	07/20/2015	11									
2	07/20/2015	07/20/2015	11									
												\$ 10

## 2. Indicate COB

Select **Yes (box 11d)** there is another health benefit plan for eye care. This will open a new section. Leave the field for “Secondary Authorization Number” blank.

\* 11d. IS THERE ANOTHER HEALTH BENEFIT PLAN FOR EYECARE?  
(if yes, complete items 9 a-d below)

Yes  No

VSP COORDINATION OF BENEFITS SECONDARY AUTHORIZATION NUMBER

## 3. Provide COB details

- Skip the **Additional Information Detail** section. (This section isn't needed)
- Complete the **Other Insured** section as shown at right.
- Click **Calculate and Continue** at the top left.

**ADDITIONAL INFORMATION DETAIL** THE FOLLOWING INFORMATION IS ONLY NECESSARY WHERE APPLICABLE

**OTHER INSURED**

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

9d. INSURANCE PLAN NAME OR PROGRAM NAME

- Enter **“Same”** in box 9
- Enter **“NA”** in box 9a
- Enter primary health plan in box 9d

## 4. Enter payment

List amount paid by primary carrier(s) in box 29, even if amount is 0.00.

28. TOTAL	*29. PAID	*30. DUE
150.00	100.00	50.00

## 5. Include patient responsibility

Use this exact language in box 19 “secondary COB claim patient resp \$XX.XX”

**ADDITIONAL INFORMATION**

Selecting Yes on any of the questions below

19. RESERVED FOR LOCAL USE **secondary COB claim patient resp \$44.00**

**Important!** Don't forget to keep copies of the Explanation of Benefits from the health plan or Medicare and the original CMS-1500 claim form in the patient's file for audit purposes.