DAVIS VISION

The Eye Care Advantage

Direct Reimbursement Claim Form

Important Information:

1 . Use this form to request reimbursement for services received from providers not in the Davis Vision network.

2. Expenses for both examinations and eyewear can be listed on this form.

3. Make sure that all sections are completed, that you and the provider(s) have signed the form, and all services, costs, and service dates have been entered (or attach signed itemized receipt from the provider).

4. Please note that the member's (or employee's) signature is required on this form.

5. Mail completed form along with your original receipts to: Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.

6. If you and your spouse are both members, you may be covered both as a member and as a dependent of a member. Similarly, your dependents may or may not be covered by both members. Please verify your coverage with your benefit office or call 1-800-999-5431.

Member I Employee Information (Please print clearly)

Member Social Security # ____ ____ - ____ ____ - ____ ____ ____ ____

Member Name: _____ _____ _____
First Middle Initial Last

Mailing Address: _____ ☐☐ ☐☐☐☐☐
Street City State Zip

Business Phone: ( ) - Home Phone: ( ) -

Patient Information

Patient Name: _____ _____ _____
First Middle Initial Last

Relationship: ☐ Member ☐ Spouse ☐ Child - DOB ☐☐ / ☐☐ / ☐☐ If student over 19, submit written proof of attendance at school when necessary

Are you and your spouse's benefits both provided by the same agency? ☐ Yes ☐ No

Provider Information

Doctor

Name: _____

Address: _____

City: _____ State: ☐☐ Zip: ☐☐☐☐☐

Federal Tax ID Number: _____

Provider Signature: _____

Phone Number: ( ) -

Dispenser (if different from examining doctor)

Name: _____

Address: _____

City: _____ State: ☐☐ Zip: ☐☐☐☐☐

Federal Tax ID Number: _____

Provider Signature: _____

Phone Number: ( ) -

SERVICE	DATE OF SERVICE	AMOUNT
1. Eye Examination		$
2. Frames		36
3. Single Vision Lenses (not plano)		$
4. Bifocal Lenses		$
5. Trifocal Lenses		$$
6. Contact Lenses		$$
7. Cataract S.V. Lenses		$
8. Cataract Bifocal Lenses		$$
9. Medically Necessary Contact Lenses		$
Total		$

Member / Employee Certification

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim to plan benefit provisions.

_____
Member's / Employee's or Authorized Person's Signature

☐☐ / ☐☐ / ☐☐
Date