Direct Reimbursement Claim Form

Important Information:

1. Use this form to request reimbursement for services received from providers who do not participate in the Davis Vision network.
2. Expenses for both examinations and eyewear can be claimed on this form.
3. Make sure that all sections are completed, that you and the providers(s) have signed the form, and that all services, charges, and service dates have been entered (or a signed itemized receipt from provider has been attached).
4. Please note that the **member's** (or employee's) signature is required on this form.
5. Mail completed form along with 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**.
7. **FOR PATIENTS RESIDING IN TN ONLY:** Tennessee state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Member/Employee Information

**** Your Member Identification No. is the number by which the company that sponsors your vision care benefits identifies you.***

(PLEASE PRINT CLEARLY)

Member Identification No.*:____________________

Member Name: ____
First Middle Initial Last

Member Social Security No.: ____________________
(complete if different than Identification No.)

Mailing Address: ____
Street City State Zip

Business Phone:______________________________ Home Phone: ______________________________
Area Code Area Code

Patient Information

Patient Name: ____
First Middle Initial Last

Relationship: D Member D Spouse D Child DOB:____________D If student aged 19 or over, attach written proof of attendance at school (if required)

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

Provider Information

Examiner	**Dispenser**
Name:____________________	Name:____________________
Address:____________________	Address:____________________
City:__________State:____Zip:______	City:__________State:____Zip:______
Federal Tax I.D. Number:____________________	Federal Tax I.D. Number: ____________________
Phone Number:____________________	Phone Number: ____________________
Provider Signature:____________________	Provider Signature: ____________________

Service	Date of Service	Amount
1. Eye Examination		$
2. Frames		$
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. Additionally, I have read and understand item 7, under Important Information, above.

____ ________________
Member/Employee or authorized person's signature **Date**