



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 Name: _____
First Middle Initial Last

Mailing Address: _____
Street City State Zip

Business Phone: _____ Home Phone: _____
Area Code Area Code

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

Patient Information

Patient Name: _____
First Middle Initial Last

Relationship: Member Spouse Child DOB: _____ 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? Yes 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 _____