



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		<i>* Your Member Identification No. is the number by which the company that sponsors your vision care benefits identifies you.</i>	
<i>(PLEASE PRINT CLEARLY)</i>			
Member Name: _____	First	Middle Initial	Last
Mailing Address: _____			Member Identification No.*: _____
Business Phone: _____			Member Social Security No.: _____
Area Code _____			(complete if different than Identification No.)
Street _____		City _____	State _____
Home Phone: _____		Zip _____	
Area Code _____		Area Code _____	

Patient Information	
Patient Name: _____	
First	Middle Initial
Last	
Relationship: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child DOB: _____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____