

Auth #: \_\_\_\_\_  
 Paid  Denied  Pended

### 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. Only services listed on this form will be considered for reimbursement.
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. If the form is incomplete, additional information may be required. This may result in a delay of payment for eligible benefits.**
4. Please submit claim reimbursement for each patient on a separate claim form.
5. Please note that the member's (or employee's or authorized person's) signature is required on this form.
6. Mail completed claim form to: **Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.**
7. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage with your benefits office or call 1-800-999-5431 or visit [www.davisvision.com](http://www.davisvision.com). The patient is responsible for the costs of all treatment and materials provided.

**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: \_\_\_\_\_ Member Identification No.\*: \_\_\_\_\_  
First Middle Initial Last

Mailing Address: \_\_\_\_\_  
Street City State Zip

Business Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Area Code Area Code

**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**

<b>Examiner</b>	<b>Dispenser</b>
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
State License Number: _____	State License Number: _____
Phone Number: _____	Phone Number: _____
Provider Signature: _____	Provider Signature: _____

Service	Date of Service	Expense(s) Incurred
1. Eye Examination	( / / )	\$
2. Frames	( / / )	\$
3. Single Vision Lenses	( / / )	\$
4. Bifocal Lenses	( / / )	\$
5. Trifocal Lenses	( / / )	\$
6. Contact Lenses	( / / )	\$
7. Cataract S.V. Lenses	( / / )	\$
8. Cataract Bifocal Lenses	( / / )	\$
9. Medically Necessary Contact Lenses	( / / )	\$
<b>Total</b>		\$

**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 provisions. Additionally, I have read and understand the fraud statement on the back of this form.

Required \_\_\_\_\_  
 Member/Employee or authorized person's signature \_\_\_\_\_ Date \_\_\_\_\_