



**ORGANIZATION OF STAFF ANALYSTS
VISION CARE DIRECT REIMBURSEMENT CLAIM FORM**

FOR INTERNAL USE ONLY

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. The benefit cannot be split between the pre-paid services from a panel provider and the direct reimbursement payment option. Only one of the methods can be used in a benefit period.
4. **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.**
5. Please submit claim reimbursement for each patient on a separate claim form.
6. Please note that the **member's** (or employee's or authorized person's) signature is required on this form.
7. Mail completed claim form to: **DavisVision Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.**
8. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage by calling 1-800-999-5431 or visiting www.davisvision.com or contacting your benefits office. The patient is responsible for the costs of all treatment and materials provided.

Member 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 / Domestic Partner Child Date of Birth: _____

Provider Information

<p>Examiner</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>State License Number: _____</p> <p>Phone Number: _____</p> <p>Provider Signature: _____</p>	<p>Dispenser (if different from examiner)</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>State License Number: _____</p> <p>Phone Number: _____</p> <p>Provider Signature: _____</p>
--	--

Service	Date of Service	Amount
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	(/ /)	\$
Total		\$

Member/Employee Certification

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

Required

 Member or authorized person's signature Date