ORGANIZATION OF STAFF ANALYSTS
VISION CARE DIRECT REIMBURSEMENT CLAIM FORM

Mail Claim To: **DAVIS VISION**
VISION CARE CLAIM FORM
P.O. Box 1525
Latham, New York 12110

Instructions:

1. This form is used to provide eligible members the ability to receive direct reimbursement. Prior to receiving services you may call **Davis Vision** toll-free at 1-800-999-5431 to verify eligibility, benefit entitlement or obtain additional information.
2. Reimbursement for examination and eyeglasses can both be claimed on this form.
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. Be sure all sections have been completed and that you and the provider(s) have signed the form.
5. Mail completed claim form to **Davis Vision** at the above address.

Member Information

(PLEASE PRINT CLEARLY)

Member Name: _____ Member Social Security 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

Examiner

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Federal Tax I.D. Number: _____

Phone Number: _____

Provider Signature: ( ) _____

Dispenser (if different from provider)

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Federal Tax I.D. Number: _____

Phone Number: _____

Provider Signature: ( ) _____

Service	Please Check	Date	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. Cataract Contact Lenses	☐		$
Total			$

Member 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 according to plan benefit provisions.

_____ / /
Member's signature **Date**

MS00353 2/4/03