



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: _____	Member Identification No.*: _____	Member Social Security No.: _____	
<div style="display: flex; justify-content: space-between;"> First Middle Initial Last </div>	(complete if different than Identification No.)		
Mailing Address: _____	City _____	State _____	Zip _____
Business Phone: _____	Home Phone: _____		
Area Code _____	Area Code _____		

Patient Information
Patient Name: _____
<div style="display: flex; justify-content: space-between;"> First Middle Initial Last </div>
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.
<div style="display: flex; justify-content: space-between;"> Member/Employee or authorized person's signature _____ Date _____ </div>