East End Health Plan

DAVIS VISION™
THE EYECARE ADVANTAGE

Direct Reimbursement Claim Form

Important Information:

1. **Use this form to request reimbursement for services received from providers not in the Davis Vision network.**
2. **Only one patient's services may be claimed on this form.** Expenses for both examinations and eyewear can be listed on this form.
3. Make sure that all sections are completed, that you and the providers(s) have signed the form, and all services, costs, and service dates have been entered (or attach signed itemized receipt from provider).
4. Please note that the **member'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

**** 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 over 19, submit written proof of attendance at school (when necessary)

Are you and your spouse's benefits both provided by the same agency? ☐ Yes ☐ No

Provider Information

Examiner

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Federal Tax I.D. Number: _____

Phone Number: _____

Provider Signature: _____

Dispenser

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Federal Tax I.D. Number: _____

Phone Number: _____

Provider Signature: _____

Service	Date of Service	Amount
1. Eye Examination		$
2. Frame and Single Vision Lenses (not plano)		$
3. Frame and Bifocal Lenses		$
4. Frame and Trifocal Lenses		$
5. Contact Lenses		$
Total		$

Member 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.

_____ _____
Member or authorized person's signature **Date**