MANAGEMENT BENEFITS FUND
VISION CARE DIRECT REIMBURSEMENT CLAIM FORM

FOR INTERNAL USE ONLY

Auth #: _____

Paid ☐ **Denied** ☐ **Pended** ☐

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 signature** is required on this form.
7. Mail completed claim form to: **Davis Vision, 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 eligibility by contacting Davis Vision toll-free at 1-800-999-5431 or visit the website **www.davisvision.com**.
9. The patient is responsible for the costs of all treatments received and materials purchased. There is no assignment of benefits to the provider(s) of services.

Member Information

(PLEASE PRINT CLEARLY)

Member Name: _____ (First / Middle Initial / Last) Member Social Security No.: _____

Mailing Address: _____ (Street / City / State / Zip)

Business Phone: _____ (Area Code) Home Phone: _____ (Area Code)

Patient Information

Patient Name: _____ (First / Middle Initial / Last)

Relationship: ☐ Member ☐ Spouse/Domestic Partner ☐ Child

Date of Birth _____

Name of Spouse's Employer: _____

Name and Address of Spouse's Insurance Carrier: _____

Provider Information

Examiner

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

State License Number: _____

Phone Number: _____

Provider Signature: _____

Dispenser (if different from examiner)

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

State License Number: _____

Phone Number: _____

Provider Signature: _____

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 Certification

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

Required

_____ _____

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