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. **Make sure that all sections are completed; that you and the provider(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.**
4. Please submit your reimbursement request for each patient on a separate claim form.
5. Please note that the **policyholder's** (or authorized person's) signature is required on this form.
6. Mail completed claim form to: **Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110**.
7. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage by calling 1800-433-9906 or visit **www.davisvision.com**. The patient is responsible for the costs of all treatment and materials provided.

Retiree/Employee Information

** Your Policyholder Identification No. is the number on your Vision ID card.*

(PLEASE PRINT CLEARLY)

Policyholder Name: ____________________ (First, Middle Initial, Last) Policyholder Identification No.*: ____________

Mailing Address: ____________________ (Street, City, State, ZIP)

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

Patient Information

Patient Name: ____________________ (First, Middle Initial, Last)

Relationship to Policyholder: ☐ Policyholder ☐ Spouse ☐ Child DOB:

Are your and your spouse's benefits both administered by Davis Vision? ☐ Yes ☐ No

Provider Information

Examiner

Name: ____________________

Address: ____________________

City: ____________ State: ____ ZIP: ________

State License Number: ____________________

Phone Number: ____________________

Provider Signature: ____________________

Dispenser

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 Polycarbonate ☐	(/ /)	$
4. Bifocal Lenses Progressive ☐ Polycarbonate ☐	(/ /)	$
5. Trifocal Lenses Polycarbonate ☐	(/ /)	$
6. Lenticular Lenses	(/ /)	$
7. Contact Lenses	(/ /)	$
Standard daily-wear ☐ Disposables ☐	(/ /)	$
Specialty (e.g., extended wear, gas permeable, hard/soft bifocal) ☐	(/ /)	$
8. Contact Lens Fitting/follow-up Daily-wear ☐ Extended Wear ☐	(/ /)	$
9. Medically Necessary Contact Lenses	(/ /)	$
	Total	$

Retiree/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 provisions. Additionally, I have read and understand the fraud statement on the back of this form.

Required

____________________ ____________

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

CL00032 10/17/06

FRAUD STATEMENT

Any person who knowingly and with intent to defraud and deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

In **Florida**, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an insurance application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In **New York**, applicants for Accident and Health Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Kentucky** and **Pennsylvania**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In **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.