SATURN®

DAVIS VISION™ THE EYECARE ADVANTAGE

Out-of-Network Reimbursement Claim Form

Instructions:

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. Be sure that all sections have been completed and that you and the provider(s) have signed the form.
4. Mail completed claim form along with original receipts to: **Vision Care Processing Unit, P.O. Box 1490, Latham, NY 12110**.

Team Member Information

**** Your Team Member Identification No. is the number by which the company that sponsors your vision care benefits identifies you.***

(PLEASE PRINT CLEARLY)

Team Member Name: _____ (First / Middle Initial / Last) Team Member 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: ☐ Employee ☐ Spouse ☐ Child DOB: _____

Provider Information

Examiner	**Dispenser (if different from provider)**
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. Lenticular Single Vision Lenses		$
8. Lenticular Bifocal Lenses		$
9. Lenticular Contact Lenses		$
Total		$

Important Information

1. Complete all TEAM MEMBER and PATIENT areas.
2. Break down all services and costs in their respective areas.
3. Make sure the provider and dispenser areas have been filled in and service dates have been entered.
4. Make sure this form has been signed by the TEAM MEMBER.
5. **FOR TEAM MEMBERS/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.

***your maximum reimbursement will be less any applicable copayment**

I certify that the information on this form is correct and authorize the Provider to release any appropriate information necessary to process this claim to plan benefit provisions. Additionally, I have read and understand item 5 under Important Information, above.

_____ / /

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