



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 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.**
4. Please submit claim reimbursement for each patient on a separate claim form.
5. Please note that the **member's** (or employee'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 with your benefits office or call 1-888-393-2583 or visit [www.ibxpress.com](http://www.ibxpress.com). The patient is responsible for the costs of all treatment and materials provided.

#### Member/Employee Information

(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: \_\_\_\_\_

#### Provider Information

<b>Examiner</b>	<b>Dispenser</b>
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
State License Number: _____	State License Number: _____
Phone Number: _____	Phone Number: _____
Provider Signature: _____	Provider Signature: _____

Service	Date of Service	Amount
1. Eye Examination	( / / )	\$
2. Frames	( / / )	\$
3. Single Vision Lenses Polycarbonate <input type="checkbox"/>	( / / )	\$
4. Bifocal Lenses Progressive <input type="checkbox"/> Polycarbonate <input type="checkbox"/>	( / / )	\$
5. Trifocal Lenses Polycarbonate <input type="checkbox"/>	( / / )	\$
6. Contact Lenses Conventional <input type="checkbox"/> Disposable <input type="checkbox"/>	( / / )	\$
7. Cataract S.V. Lenses* Polycarbonate <input type="checkbox"/>	( / / )	\$
8. Cataract Bifocal Lenses* Progressive <input type="checkbox"/> Polycarbonate <input type="checkbox"/>	( / / )	\$
9. Medically Necessary Contact Lenses*	( / / )	\$
<b>Total</b>		\$

(\* These services are not applicable for Keystone 65, Personal Choice 65, Security 65 or 65 Special members. Please refer to your medical coverage for these benefits.

#### Member Certification

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 a person to criminal and civil penalties. PROVIDERS: By signing this document, you swear or affirm that the services or materials for which this claim is being made were necessary and were, in fact, furnished.

#### For Keystone Health Plan East Participants:

For participants in ERISA self-funded products, references to subscriber/member shall include participants, and payments for covered services will be made by Keystone Health Plan East on behalf of the employer group.

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

Required \_\_\_\_\_ / /  
 Member's or authorized person's signature Date