


**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. Expenses for both examinations and eyewear can be listed on this form.
3. Make sure that all sections are completed, that you and the provider(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** (or employee's) signature is required on this form.
5. Mail completed form along with original receipts to: **Vision Care Processing Unit, P.O. Box 2270, Schenectady, NY 12301.**
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.**

**Member/Employee Information** (PLEASE PRINT CLEARLY)

Member Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Member Name: \_\_\_\_\_  
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**

**Doctor**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Federal Tax I.D. Number: \_\_\_\_\_  
 Provider Signature: \_\_\_\_\_  
 Phone Number: ( ) \_\_\_\_\_

**Dispenser** (if different than the examining doctor)

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Federal Tax I.D. Number: \_\_\_\_\_  
 Provider Signature: \_\_\_\_\_  
 Phone Number: ( ) \_\_\_\_\_

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. Cataract S.V. Lenses		\$ _____
8. Cataract Bifocal Lenses		\$ _____
9. Medically Necessary Contact Lenses		\$ _____
<b>Total</b>		\$ _____

**Member/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 benefit provisions.

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