

Verizon (formerly Bell Atlantic North Associates)

Direct Reimbursement Claim Form



Important Information:

1. Use this form to request reimbursement for routine vision services received from non Davis Vision providers.
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 providers(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 employee's signature is required on this form.
5. Mail completed form along with original receipts to: Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.

Employee Information (You must provide your Employee Identification No. if the company that sponsors your vision care benefits provides one)

(PLEASE PRINT CLEARLY)

Employee Name: _____ Employee Identification No.*: _____
First Middle Initial Last
 Employee Social Security No.: _____
(complete if different than Identification No.)

Mailing Address: _____
Street City State Zip

Business Phone: _____ Home Phone: _____
Area Code Area Code

Patient Information

Patient Name: _____
First Middle Initial Last

Relationship: Employee 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

<p>Examiner</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Federal Tax I.D. Number: _____</p> <p>Please check appropriate box: <input type="checkbox"/> SSN <input type="checkbox"/> EIN</p> <p>If EIN, check one: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other</p> <p>Phone Number: _____</p> <p>Provider Signature: _____</p>	<p>Dispenser (if different from provider)</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Federal Tax I.D. Number: _____</p> <p>Please check appropriate box: <input type="checkbox"/> SSN <input type="checkbox"/> EIN</p> <p>If EIN, check one: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other</p> <p>Phone Number: _____</p> <p>Provider Signature: _____</p>
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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		\$
Total		\$

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. (Please check one and sign):

_____ Employee's or authorized person's signature (Reimbursement to employee)

_____ Insured or Authorized person's signature (I authorize payment of my vision benefit reimbursement to the above provider or supplier of services) (Assignment of Benefits)

Date _____

