# General Motors Corporation
# IUE-CWA and Non-Represented Enrollees Vision Coverage
## *Out-of-Network Claim Form*

**FOR INTERNAL USE ONLY**
Auth #: _____
Paid ☐ Denied ☐ Pended ☐

**Instructions:**
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 1490, 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-GM-EYES0 or visit **www.davisvision.com**. The patient is responsible for the costs of all treatment and materials provided.
8. **FOR 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.

## *Employee Information*

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

Employee Identification No.*:_____

Employee Name: _____
First Middle Initial Last

Mailing Address: _____
Street City State Zip

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

## *Alternate Recipient Information*

**Please complete the information below if this claim is for an alternate recipient, covered under QMCSO***

Alternate Recipient's Name: _____
First Middle Initial Last

Legal Guardian's Name:(if alternate recipient is a child) _____
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: ☐ Employee ☐ Spouse ☐ Child - DOB _____ ☐ Alternate Recipient (covered under QMCSO*) - DOB _____

## *Other Vision Benefits*

Are you, your spouse, or your dependents also covered for vision benefits through any other employer group, union welfare plan or Medicare?
☐ Yes ☐ No If no, proceed to Employee Certification below.

If yes, attach the itemized bill along with a copy of the Explanation of Benefits (EOB – the statement describing how your benefits were paid) from the other plan or Medicare. If an EOB from the other plan or Medicare is not available, please provide the name and address of the employer and other insurance company providing vision benefits.

Name and Identification # of person covered:

_____ ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Employer Name: _____ Insurance Administrator: _____

Address: _____ Address: _____

## *Employee Certification*

I authorize the release of any information regarding this claim. I certify the information provided is correct and that I have not been previously reimbursed for these services, and understand that any intentional failure to complete this claim form accurately may lead to disciplinary action and/or claim denial. If this claim is for an alternate recipient, I certify that a Qualifying Court Order directs such payment.

Employee, Alternate Recipient or Legal Guardian Signature: Required Date:_____

***QMCSO – Qualified Medical Child Support Order**

## *Provider Information (to be completed by provider)*

### *Examiner*

Name: _____ ☐ MD/DO ☐ OD

Address: _____

City: _____ State: _____ Zip: _____

State License Number: _____

**Provider Signature:** _____ Phone Number: (  ) _____

### *Dispenser (if different from examiner)*

Name: _____ ☐ MD/DO ☐ OD

Address: _____

City: _____ State: _____ Zip: _____

State License Number: _____

**Provider Signature:** _____ Phone Number: (  ) _____

## *Services Rendered and Charges*

Please check the box next to the services provided, enter the actual charged or attach itemized receipt:

| Service | Date of Service | Please Check | Expense(s) Incurred |
|---|---|---|---|
| Eye Examination | (  /  /  ) | ☐ | $ |
| Frames | (  /  /  ) | ☐ | $ |
| Prescription Single Vision Lenses | (  /  /  ) | ☐ | $ |
| Prescription Bifocal Lenses | (  /  /  ) | ☐ | $ |
| Prescription Trifocal Lenses | (  /  /  ) | ☐ | $ |
| Elective Contact Lenses | (  /  /  ) | ☐ | $ |
| Medically Necessary Contact Lenses* | (  /  /  ) | ☐ | $ |
| Cataract Single Vision Lenses | (  /  /  ) | ☐ | $ |
| Cataract Bifocal Lenses | (  /  /  ) | ☐ | $ |
| Cataract Contact Lenses | (  /  /  ) | ☐ | $ |
| Eyeglass Tinting | (  /  /  ) | ☐ | $ |
| | | **Total** | $ |

***Provider documentation of medical necessity is required. Claim will be paid as elective (cosmetic) without such documentation.**