



# Refractive Correction Benefit

## Direct Reimbursement Claim Form

### Important Information:

1. Use this form to request reimbursement for Refractive Vision Correction services received.
2. 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 (be sure to attach a copy of the bill from your provider).
3. Please note that the beneficiary's signature is required on this form.
4. Mail completed form along with other documents to: **Vision Care Processing Unit, P.O. Box 1620, Latham, NY 12110.**
5. **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.

### Member/Employee Information

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

(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: \_\_\_\_\_ Confirmation Number: \_\_\_\_\_  
First Middle Initial Last

Relationship:  Member  Spouse/Domestic Partner  Child DOB: \_\_\_\_\_

### Provider Information

#### Surgeon/Facility:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Federal Tax I.D. Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Service	Date of Service	Amount
1. Initial Evaluation		\$
2a. Procedure Performed - OD (Right eye)		\$
Specify:		
2b. Procedure Performed - OS (Left eye)		\$
Specify:		
3. Follow-up		\$
<b>Total</b>		\$

### Beneficiary Certification

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.

Beneficiary's signature \_\_\_\_\_ Date \_\_\_\_\_