Direct Reimbursement Claim Form

FOR INTERNAL USE ONLY		
Auth #: ______		
Paid ☐	Denied ☐	Pended ☐

Important Information:

1. Claims administration for your vision program is performed by Davis Vision under a contractual arrangement. 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: **Davis Vision, 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 1-800-223-4795 or visit **www.highmark.com**. The patient is responsible for the costs of all treatment and materials provided.

Member/Employee Information

** Your Member Identification No. is the number found on your Vision Identification card.*

(PLEASE PRINT CLEARLY)

Member Name: ______ First ______ Middle Initial ______ Last ______ Member Identification No.*: ______

Mailing Address: ______ Street ______ City ______ State ______ Zip ______

Business Phone: Area Code ______ Home Phone: Area Code ______

Patient Information

Patient Name: ______ First ______ Middle Initial ______ Last ______ Relationship: ☐ Member ☐ Spouse ☐ Child DOB: ______

Other Vision Insurance Coverage: (name, address, policy number) ______

Provider Information

General Standard

If Lenses were prescribed, was the general standard met according to the definition below. ☐ Yes ☐ No

General Standard: Change of at least .50 diopter sphere in one eye or combined between both eyes or an increase in one line of Snellen acuity (distance or reduced near).

If no, indicate replacement reason:

☐ Loss or theft ☐ Breakage or damage

☐ Patient preference ☐ Medically related reasons, please explain or attach ______

Examiner	**Dispenser**
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 ☐	(/ /)	$
4. Bifocal Lenses Progressive ☐ Polycarbonate ☐	(/ /)	$
5. Trifocal Lenses Polycarbonate ☐	(/ /)	$
6. Lenticular Lenses	(/ /)	$
7. Contact Lenses	(/ /)	$
Standard daily wear ☐ Disposables ☐	(/ /)	$
Specialty (e.g. extended wear, gas permeable, hard/soft bifocal) ☐	(/ /)	$
8. Contact Lens Fitting/follow-up Daily Wear ☐ Extended Wear ☐	(/ /)	$
9. Medically Necessary Contact Lenses	(/ /)	$
	Total	$

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 provisions. Additionally, I have read and understand the fraud statement on the back of this form.

Required

Member/Employee or authorized person's signature ______ **Date** ______

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