



# Laser Vision Correction

## Direct Reimbursement Claim Form

### Important Information:

1. Use this form to request reimbursement for Laser 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 **member's** (or employee's) signature is required on this form.
4. Mail completed form along with other documents to: **Laser Correction Processing Unit, P.O. Box 2270, Schenectady, NY 12301.**

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

Member Name: \_\_\_\_\_ Member Social Security 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		\$
2. Lasik OD (Right Eye)		\$
3. Lasik OS (Left Eye)		\$
4. PRK OD		\$
5. PRK OS		\$
6. Follow-up		\$
<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/Employee or authorized person's signature

\_\_\_\_\_  
 Date