DAVIS VISION™
THE EYECARE ADVANTAGE

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: **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 Identification No.: _____

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		$
Total		$

Member/Employee 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.

I authorize payment of my vision benefit reimbursement to the ☐ provider, ☐ supplier of services, or ☐ patient above.

_____ _____ _____ _____
Employee's or authorized person's signature **Date** **Employee's or authorized person's signature** **Date**