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Vision Services Reimbursement Form

Your Health Plan might offer direct reimbursement for certain vision services when provided out-of-network. Refer to your Plan's *Evidence of Coverage* document for specific limitations and coverage eligibility details. Details of services provided, and proof of payment is required for consideration of reimbursement. You may need your vision service provider to supply necessary information, such as service codes, and assist you in completing this form.

To request a review for consideration of member direct reimbursement, you must submit the following:

- EyeQuest *Vision Services Reimbursement Form* - with member signature
- Your itemized receipt(s) - including specific description of services provided and proof of payment for services being requested for reimbursement.
- Claim form (If provided to you by your eye doctor/optical provider)

1: Member Details			
Title: Mr. / Mrs. / Ms.			
First name:	Middle initial:	Last name:	
Date of birth (mm/dd/yyyy): _____ /_____ /_____		Gender: Male / Female	
ID number (as shown on your Health Plan member ID card):			
Member's full address:			Apt.:
City:		State:	Zip code:
Preferred phone number:			
Email:			
2: Provider/Claim Information			
Name of vision provider:			
Provider NPI or Tax ID number:			
Address of services rendered:			Suite:
City:		State:	Zip code:
Provider phone number:			
Provider Fax Number:			

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3: Invoice and Receipt Information			
Fill in the details of each vision service submitted with this Request for Reimbursement:			
Date of Service (mm/dd/yyyy)	**Service Rendered by Provider/ Service Detail (e.g. eye exam, glasses, contact lenses)**	**Procedure Code(s)**	**Paid Amount**

Important Notice: **Do not submit a request for reimbursement for services paid for with a Health Plan provided "Flexible Benefit Card". Payments for services made with these credit cards are not reimbursable.**

Member or Personal Representative signature is required.

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is purposely misleading or fraudulent I may be subject to civil penalties for false healthcare claims. I also understand EyeQuest may request any additional information it deems necessary to verify that services were received, and payment was made.

Printed Name	Signature	Signature Date

Please submit this form, receipts and documentation items to:

EyeQuest
Attention: Vision Claim Processing
PO Box 433
Milwaukee, WI 53201-2906
Fax: 1-888-696-9952

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Member Vision Services Reimbursement Form Help Sheet

Form Field	Description or Requirement
Member's Name	Include **"First Name" – "Middle Initial" - "Last Name"** of the person receiving the services.
Member's Date-of-Birth	Include date of birth; **Month / Day / Year** for the person receiving the services
Member ID #	Include the Member's Health Plan ID number; found on the front of the ID Card
Full Address & Phone #	Include the current full mailing address and daytime phone number for the person (or representative) submitting this form
Email Address	Include the email address for the person submitting this form
Name, Address, NPI or Tax ID#, and phone number of the Vision Services Provider who provided the requested services	Include this essential information for the Vision Provider who performed the services you are requesting reimbursement for.**
Invoices and Receipts: • Date(s) of Service • Services Received • CPT codes • Amount paid	 Date you received the service for which you are requesting reimbursement Describe the vision service(s) received. Provide proof of service.** Provide the procedure code (if applicable) for the vision service received and for which you are requesting reimbursement** Include the amount the member paid for each service received and for which you are requesting reimbursement**
Proof of Payment and Other Documentation	Submit legible proof of payment for the services received. Valid documentation might include a copy of a cancelled check (front and back); a credit card statement or itemized receipt showing the dates of service, name of the provider or business paid; or a statement on the provider's letterhead detailing the services received and payment made to the provider. *

** You will need to obtain this information from your vision provider
*The credit card used for payment should not be a Health Plan issued "Flexible Benefits" card. Your signed attestation of that fact is found on the preceding page.