Central Pennsylvania Teamsters Health & Welfare Fund

FOR INTERNAL USE ONLY
Auth #: _____
Paid ☐ **Denied** ☐ **Pended** ☐

Direct Reimbursement Claim Form

Important Information:

1. 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: **Vision Care Processing Unit, 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 1-800-999-5431 or visit **www.davisvision.com**. The patient is responsible for the costs of all treatment and materials provided.
8. **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 care 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: _____
First Middle Initial Last

Relationship: ☐ Member ☐ Spouse ☐ Child DOB: _____

Are you and your spouses benefits both provided by the same agency? ☐ Yes ☐ No

Provider Information

Examiner

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

State License Number: _____

Phone Number:_____

Provider Signature: _____

Dispenser

Name:_____

Address:_____

City: _____ State: ____ Zip:_____

State License. Number: _____

Phone Number: _____

Provider Signature: _____

Service	Date of Service	Amount
1. Eye Examination	(/ /)	$
2. Frames	(/ /)	$
3. Single Vision Lenses	(/ /)	$
4. Bifocal Lenses	(/ /)	$
5. Trifocal Lenses	(/ /)	$
6. Contact Lenses	(/ /)	$
7. Cataract S.V. Lenses	(/ /)	$
8. Cataract Bifocal Lenses	(/ /)	$
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 item 8, under Important Information, above.

Required

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