



HOUSE STAFF BENEFITS PLAN

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How To File An Out-of-Network Claim

- A. Fill out the Member/Employee information and Patient Information sections on the following page.
- B. If you have an itemized bill from your provider or from your online purchase (e.g. 1800contacts.com) attach your itemized bill to the claim form. You do not need to complete the Provider Information section as long as you have an itemized bill from your provider.
- C. If you **do not** have an itemized bill, have your provider complete the Provider Information section and list dates of service and expenses incurred.
- D. Sign and date your claim form under Member/Employee Certification.
- E. Mail your completed claim form to: **Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.**

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.

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: _____ If student aged 19 or over, attach written proof of attendance at school (if required)

Are you and your spouse's benefits both provided by the same agency? Yes No

Provider Information

<p>Examiner</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: ____ Zip: _____</p> <p>State License Number: _____</p> <p>Phone Number: _____</p> <p>Provider Signature: _____</p>	<p>Dispenser</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: ____ Zip: _____</p> <p>State License Number: _____</p> <p>Phone Number: _____</p> <p>Provider Signature: _____</p>
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Service	Date of Service	Expense(s) Incurred
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 the fraud statement on the back of this form.

Required

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

FRAUD STATEMENT

Any person who knowingly and with intent to defraud and deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

In **Florida**, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an insurance application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In **New York**, applicants for Accident and Health Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Kentucky** and **Pennsylvania**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In **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.

For Washington, D.C. residents:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.