**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 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 479, Troy, NY 12181.**
7. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage with your benefits office or call **1-888-444-5591**. 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*

**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 | 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 STATEMENTS

*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 and/or criminal penalties, which may include the payment of restitution, fines, imprisonment, loss of insurance and/or denial of benefits, depending upon state law.*

In **Arizona**, for your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

In **California**, for your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 Hampshire**, any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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**, 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**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

In **Minnesota**, a person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

In **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 **Puerto Rico**, any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than $5,000 and not more than $10,000, or a fixed term of imprisonment for 3 years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of 5 years, if extenuating circumstances are present, it may be reduced to a minimum of 2 years. Noncompliance will result in administrative fines. Failure to include this notice on the indicated forms shall not constitute a defense for the insured or the third party claimant.

For **Colorado**, **Maine**, **Tennessee**, **Virginia**, **Washington**, & **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.