Vision Care Direct Reimbursement Claim Form

Important Information:

1. Use this form to request reimbursement for services received from a non-participating provider.
2. Expenses for both eye examinations and eyewear can be listed on this form.
3. Make sure that all applicable sections are completed, that you and the provider have signed the form, and all services, costs, and service dates have been entered. A signed itemized receipt from the provider must be attached to this claim form.
4. Please note that the **member's** signature is required on this form.
5. Mail completed form along with original receipts to: **CSEA Employee Benefits Fund, PO Box 516, Latham, NY 12110.**
6. To verify your current eligibility or speak with a representative, contact us at 1-800-323-2732.
7. **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 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: _____ (First / Middle Initial / Last)

Member Identification No.*: _____

Member Social Security No.: _____
(complete if different than Identification No.)

Mailing Address: _____ (Street / City / State / Zip)

Business Phone: _____ (Area Code)

Home Phone: _____ (Area Code)

Patient Information

Patient Name: _____ (First / Middle Initial / Last)

Relationship: ☐ Member ☐ Spouse ☐ Child (Date of Birth): _____ ☐ Other

Provider Information

Examiner

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Federal Tax I.D. Number: _____

Phone Number: _____

Provider Signature: _____

Dispenser

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Federal Tax I.D. Number: _____

Phone Number: _____

Provider Signature: _____

Service	Date of Service	Amount
1. Eye Examination		$
2. Frames		$
3. Single Vision Lenses (not plano)		$
4. Bifocal Lenses		$
5. Trifocal Lenses		$
6. Contact Lenses		$
7. Cataract S.V. Lenses		$
8. Cataract Bifocal Lenses		$
Total		$

Member Certification

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim according to plan benefit provisions.

_____ _____

Member signature **Date**