

Direct Reimbursement Vision Claim Form

FOR INTERNAL USE ONLY		
Auth #:	_____	
Paid <input type="checkbox"/>	Denied <input type="checkbox"/>	Pended <input type="checkbox"/>

Important Information:

1. Davis Vision is a separate company that performs claims administration for your vision program. 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: **Davis Vision, 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 1-800-223-4795 or visit www.highmark.com. The patient is responsible for the costs of all treatment and materials provided.

Member/Employee Information <i>(PLEASE PRINT CLEARLY)</i>	<i>* Your Member Identification No. is the number found on your Vision Identification card.</i>
Member Name: _____ <small>First Middle Initial Last</small>	Member Identification No.*: _____
Mailing Address: _____ <small>Street City State Zip</small>	
Business Phone: _____ <small>Area Code</small>	Home Phone: _____ <small>Area Code</small>

Patient Information	
Patient Name: _____ <small>First Middle Initial Last</small>	Relationship: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child DOB: _____
Other Vision Insurance Coverage: (name, address, policy number) _____	

Provider Information	
General Standard	
If Lenses were prescribed, was the general standard met according to the definition below. <input type="checkbox"/> Yes <input type="checkbox"/> No	
General Standard: Change of at least .50 diopter sphere in one eye or combined between both eyes or an increase in one line of Snellen acuity (distance or reduced near).	
If no, indicate replacement reason:	
<input type="checkbox"/> Loss or theft	<input type="checkbox"/> Breakage or damage
<input type="checkbox"/> Patient preference	<input type="checkbox"/> Medically related reasons, please explain or attach _____

Examiner	Dispenser
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
State License Number: _____	State License Number: _____
Phone Number: _____	Phone Number: _____
Provider Signature: _____	Provider Signature: _____

Service	Date of Service	*Dress <input type="checkbox"/>	*Safety <input type="checkbox"/>	Expense(s) Incurred
1. Eye Examination	(/ /)			\$
2. Frames	(/ /)			\$
3. Single Vision Lenses Polycarbonate <input type="checkbox"/>	(/ /)			\$
4. Bifocal Lenses Progressive <input type="checkbox"/> Polycarbonate <input type="checkbox"/>	(/ /)			\$
5. Trifocal Lenses Polycarbonate <input type="checkbox"/>	(/ /)			\$
6. Lenticular Lenses	(/ /)			\$
7. Contact Lenses	(/ /)			\$
Standard daily wear <input type="checkbox"/> Disposables <input type="checkbox"/>	(/ /)			\$
Specialty (e.g. extended wear, gas permeable, hard/soft bifocal) <input type="checkbox"/>	(/ /)			\$
8. Contact Lens Fitting/follow-up Daily Wear <input type="checkbox"/> Extended Wear <input type="checkbox"/>	(/ /)			\$
9. Medically Necessary Contact Lenses	(/ /)			\$
*Please submit a separate claim form for safety and dress	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 _____
Health care benefit programs are issued or administered by Highmark Blue Shield or Highmark Health Insurance Company, independent licensees of the Blue Cross and Blue Shield Association.	
CL00037 8/18/11	

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.