# Laser Vision Correction

## Direct Reimbursement Claim Form

**Important Information:**
1. Use this form to request reimbursement for Laser Vision Correction services received.
2. Make sure that all sections are completed, that you and the providers(s) have signed the form, and all services, costs, and service dates have been entered (be sure to attach a copy of the bill from your provider).
3. Please note that the **member's** (or employee's) signature is required on this form.
4. Mail completed form along with other documents to: **Vision Care Processing Unit, P.O. Box 1620, Latham, NY 12110**.
5. **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 benefits identifies you.***

*(PLEASE PRINT CLEARLY)*

Member Identification No.: ______________________

Member Name: ______________________________ (First / Middle Initial / Last)

Member Social Security No.: ______________________

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

Business Phone: ______________________ (Area Code)

Home Phone: ______________________ (Area Code)

### *Patient Information*

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

Confirmation Number: ______________________

Relationship: ☐ Member ☐ Spouse/Domestic Partner ☐ Child DOB: ______

### *Provider Information*

**Surgeon/Facility:**

Name: ______________________________

Address: ______________________________

City: ______________________ State: ______________________ Zip: ______________________

Federal Tax I.D. Number: ______________________________

Phone Number: ______________________________

Provider Signature: ______________________________

| Service | Date of Service | Amount |
|---|---|---|
| 1. Initial Evaluation | | $ |
| 2. Lasik OD (Right Eye) | | $ |
| 3. Lasik OS (Left Eye) | | $ |
| 4. PRK OD | | $ |
| 5. PRK OS | | $ |
| 6. Follow-up | | $ |
| **Total** | | $ |

### *Member/Employee Certification*

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

______________________ ______________
**Employee's or authorized person's signature** **Date**

I authorize payment of my vision benefit reimbursement to the ☐ provider, ☐ supplier of services, or ☐ patient above.

______________________ ______________
**Employee's or authorized person's signature** **Date**