I.A.T.S.E. National Health & Welfare Fund

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 must be claimed on this form at the same time. You may not "split" your services.
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 (or a signed itemized receipt from provider has been attached).
4. **Only one patient's services may be claimed on this form.** Please note that the **member's** (or employee's) signature is required below.
5. Mail completed form along with original receipts to: **Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110**.
6. If you and your spouse are both members, you may be covered both as a member and as a dependent of a member. Similarly, your dependents may or may not be covered by both members. Please verify your coverage with your benefit office or call **1-800-999-5431**.
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/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: _____ (First / Middle Initial / Last) Member 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 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: _____

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		$
9. Medically Necessary Contact Lenses		$
Total		$

****Please note: All services must be submitted within 18 months of the date of service.**

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 benefit provisions. Additionally, I have read and understand item 7, under Important Information, above.

_____ _____

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