Verizon (formerly Bell Atlantic North Associates)
Direct Reimbursement Claim Form

DAVIS VISION™
THE EYECARE ADVANTAGE

Important Information:

1. Use this form to request reimbursement for routine vision services received from non Davis Vision providers.
2. Expenses for both examinations and eyewear can be listed on this form.
3. 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 (or attach signed itemized receipt from provider).
4. Please note that the **employee's** signature is required on this form.
5. Mail completed form along with original receipts to: **Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.**

Employee Information

Your Employee Identification No. is the number by which the company that sponsors your vision care benefit identifies you.

(PLEASE PRINT CLEARLY)

Employee Identification No.*: _____

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

Employee 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: ☐ Employee ☐ Spouse ☐ Child DOB: _____ ☐ If student over 19, submit written proof of attendance at school (when necessary)

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: _____

Please check appropriate box: ☐ SSN ☐ EIN

If EIN, check one: ☐ Individual ☐ Partnership ☐ Corporation ☐ Other

Phone Number: _____

Provider Signature: _____

Dispenser (if different from provider)

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Federal Tax I.D. Number: _____

Please check appropriate box: ☐ SSN ☐ EIN

If EIN, check one: ☐ Individual ☐ Partnership ☐ Corporation ☐ Other

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		$

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.
(Please check one and sign):

☐ _____
Employee's or authorized person's signature
(Reimbursement to employee)

☐ _____
Insured or Authorized person's signature
(I authorize payment of my vision benefit reimbursement to the above provider or supplier of services)
(Assignment of Benefits)

_____
Date

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