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

Important Information:

1. Use this form to request reimbursement for services received from out-of-network providers (not in the Davis Vision network).
2. **Only one patient's services may be claimed on this form.** 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 or patient's signature is required on this form to ensure that reimbursement is made directly to the employee.
5. Mail completed form along with original receipts to: **Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110**.
6. If you have any questions, please call **1-877-999-7006**.
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.

Employee Information

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

(PLEASE PRINT CLEARLY)

Employee Name: ______________________________ Employee Identification No.*: ____________

First Middle Initial Last

Mailing Address: ______________________________

Street City State Zip

Business Phone: ____________________ Home Phone: ____________________

Area Code 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	Expense(s) Incurred
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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