



Vision Care Direct Reimbursement Claim Form

Important Information:

1. Use this form to request reimbursement for services received from a non-participating provider.
2. Expenses for both eye examinations and eyewear can be listed on this form.
3. Make sure that all applicable sections are completed, that you and the provider have signed the form, and all services, costs, and service dates have been entered. A signed itemized receipt from the provider must be attached to this claim form.
4. Please note that the **member's** signature is required on this form.
5. Mail completed form along with original receipts to: **CSEA Employee Benefits Fund, PO Box 516, Latham, NY 12110.**
6. To verify your current eligibility or speak with a representative, contact us at 1-800-323-2732.

Member Information (PLEASE PRINT CLEARLY)

Member Name: _____ Member Social Security 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: Member Spouse Child (Date of Birth): _____ Other

Provider Information

Examiner	Dispenser
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Federal Tax I.D. Number: _____	Federal Tax I.D. Number: _____
Phone Number: _____	Phone Number: _____
Provider Signature: _____	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		\$

Member Certification

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

 Member signature Date