MEMBER REIMBURSEMENT FORM - VISION SERVICES

Member Services 855-844-0626

Mail Claims To:
Direct Dental Vision Claims
PO Box 192
Milwaukee, WI 53201

INSTRUCTIONS: If you have paid your provider in full for Vision services, please complete this form in its entirety.
REQUIRED: Ask your provider for a statement of services which should include; **procedure code**, quantity, date of service and amount paid. Your provider can assist you with completion of the form. **Proof of payment is required.**

To ensure proper reimbursement, please complete this form in full. Claim forms missing information cannot be processed.

PATIENT INFORMATION			
PATIENT FIRST NAME	PATIENT LAST NAME	DOB	
PATIENT ID NUMBER	PHONE		
ADDRESS	CITY	STATE	ZIP
PARENT/GUARDIAN or CONTACT NAME (If Applicable)	RELATIONSHIP	PHONE	

PROVIDER INFORMATION				
NPI#	FIRST NAME	LAST NAME	PHONE	
ADDRESS	CITY	STATE	ZIP	

VISION SERVICES RECEIVED				
Date of Service	Procedure Code	Description	Amount Paid	QTY

I certify that the above and attached information is accurate and hereby authorize my provider to supply any information regarding the services rendered.

Name/Signature _____ Date _____

PLEASE ATTACH YOUR PROVIDER'S STATEMENT OF BILLED CHARGES MEETING THE CRITERIA DESCRIBED ABOVE