

Vision Care Direct Reimbursement Claim Form



1. Use this form to request reimbursement for services received from a non-participating provider.
2. Expenses for both eye examination 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. Mailed completed form along with original receipts to: CSEA Employee Benefit Fund, PO Box 516, Latham, NY 12110
6. To verify your current eligibility or speak with a representative, contact us at (800) 323-2732 ext. 880.

Member Information	
*Your Member Identification # is the number by which the company that sponsors your vision care benefits identifies you.	
Member Name: _____	EBF ID No.* _____
Mailing Address: _____	Home Phone: _____
Business Phone: _____	

Patient Information	
Patient Name: _____	
Relationship: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child (Date of Birth): _____ <input type="checkbox"/> Other	

Provider Information		
Examiner	Dispenser	
Name: _____	Name: _____	
Address: _____	Address: _____	
City _____ State _____ Zip _____	City: _____ State _____ Zip _____	
Federal Tax I.D. #: _____	Federal Tax I.D. # _____	
Phone: _____	Phone: _____	
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 according to plan benefit provisions.	
Member Signature _____	Date _____