CSEA Employee Benefit Fund Vision Care Direct Reimbursement Claim Form



Form must be completed and signed by the CSEA Employee Benefit Fund member. All required documentation must be attached. **Incomplete forms will be returned.**

MAIL COMPLETED CLAIM TO

CSEA Employee Benefit Fund PO Box 516 Latham, NY 12110-0516

CLAIMS ARE NOT ACCEPTED BY FAX OR EMAIL

MAJOR PLAN FEATURES

- This benefit reimburses an allowance toward the cost of a non-participating provider.
- · Expenses for both eye examination and eyewear are reimbursable.

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Provider may complete and sign form or member may attach an itemized billing statement for services rendered.

mber's Name		EBF ID# DOB Apt #				
tient's Name						
iling Address						
y						
ytime Phone #						
TO BE COMPLETED BY PROVIDE	R (PLEASE PRINT)					
ovider Information						
Examiner	Dispenser	Same as Exami	ner			
Name	Name					
Address	Address					
CityStateZip	City		StateZip			
Federal Tax ID #	Federal Tax ID #					
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						