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

MAJOR PLAN FEATURES

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

INSTRUCTIONS

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

TO BE COMPLETED BY MEMBER (PLEASE PRINT)

Member's Name _____ EBF ID# _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip Code _____

Daytime Phone # _____ Email _____

TO BE COMPLETED BY PROVIDER (PLEASE PRINT)

Patient Name _____ DOB _____

Relationship: ☐ Member ☐ Spouse ☐ Child ☐ Other: _____

Provider Information

Examiner

Name _____

Address _____

City _____ State _____ Zip _____

Federal Tax ID # _____

Dispenser ☐ Same as Examiner

Name _____

Address _____

City _____ State _____ Zip _____

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		

PROVIDER CERTIFICATION: I hereby certify that the above procedures have been completed.

Provider's Signature _____ Date _____

MEMBER CERTIFICATION: I hereby 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's Signature _____ Date _____