

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 eyewear 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 _____ Dispenser Same as Examiner
 Name _____ Name _____
 Address _____ Address _____
 City _____ State _____ Zip _____ City _____ State _____ Zip _____
 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		

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 _____