

# Vision Services Claim Form



Anthem Blue Cross and Blue Shield  
Member Services:  
1-800-451-1527  
358-1551 (Richmond area)

This form will allow you to request reimbursement for covered vision services, eyeglass lenses, frames or contact lenses that you purchased from a provider not participating with the Anthem Blue Cross and Blue Shield Davis Vision Network.

**Instructions:** Please complete all appropriate areas on the front and back of this form so we can provide you with the fastest service possible. An itemized, dated receipt indicating that you have already paid for the vision care or items must be attached. If the eyewear receipt does not include your name, attach a copy of the prescription as well.

**Mail this completed form and attachments to:**

Vision Care Processing Unit  
P.O. Box 1525  
Latham, NY 12110

<i>Subscriber and Patient Information:</i>	
Subscriber's Name (Last, First, M.I.)	Subscriber's ID#
Subscriber's Address (Street, City, State, Zip Code)	Group Number (as printed on ID card)
Patient's Name (Last, First, M.I.)	Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other

<i>Provider Information:</i>	
<b>Doctor</b>	<b>Dispenser</b> (if different than the examining doctor)
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Federal Tax I.D. Number: _____	Federal Tax I.D. Number: _____
Provider Signature (optional): _____	Provider Signature (optional): _____
Phone Number: _____	Phone Number: _____

Please complete the back of this form.

<i>Services/Eyewear Received:</i>		
<i>Service/Eyewear Date of Service Amount</i>	<i>Date of Service</i>	<i>Amount</i>
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	/ /	\$
9. Medically Necessary Contact Lenses	/ /	\$
<b>Total</b>		<b>\$</b>

I certify that the information reported on and attached to this claim is accurate to the best of my knowledge and is for optical services or materials purchased for my personal use or for the personal use of a covered dependent in accordance with my Benefit Book.

Signature \_\_\_\_\_ Date \_\_\_\_\_