



Member Reimbursement Claim Form

Use this form for reimbursement of services received from an out-of-network provider, or when you have utilized an in-store sale or promotion from an in-network provider.

Subscriber Information *(Please print clearly)*

Subscriber Name	Daytime Phone ()	Evening Phone ()	
Mailing Address	City	State	Zip
Subscriber ID Number	Name of Employer		

Patient Information

Patient Name	Date of Birth / /	Authorization Number	Full Time Student* <input type="checkbox"/> Yes <input type="checkbox"/> No <small>*Verification may be required</small>
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Claim Information

Date of Service: _____	Single Vision Lenses: \$ _____	Contacts: \$ _____
Exam: \$ _____	Bifocal Lenses: \$ _____	Contact Lens Fitting Exam: \$ _____
Frame: \$ _____	Trifocal Lenses: \$ _____	Extra Ad-Ons: \$ _____
	Progressive Lenses: \$ _____	Other: _____ \$ _____

Is the provider an in-network provider?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Provider Name <u>CONTACTLENS.COM</u>	Phone Number <u>(800) 536-7327</u>	
If you saw an in-network provider:		
Are you applying for reimbursement after using an in-store sale or promotion? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If you see an in-network provider but choose to take advantage of a sale, coupon, or other in-store special, the provider may require that you pay in full and then submit your receipt to Superior Vision for reimbursement at the out-of-network rates.		
If you have co-pays, these are paid to your in-network provider at the time of your visit. You are also responsible for paying for any services or materials that are not covered or that exceed your benefit plan coverage. If you paid in full for your service, please provide a brief explanation as to why your provider did not bill us on your behalf.		

Mail or fax a copy of the itemized invoice or receipt imprinted with the provider's name and address along with this form to the contact information below. Please retain the original for your records.

<p>Superior Vision Attn: Claims Processing P.O. Box 967 Rancho Cordova, CA 95741 Fax: (916) 852-2277</p>

Questions? Please call our Customer Service department at (800) 507-3800