AmeriHealth

Davis Vision Network Direct Reimbursement Claim Form

Important Information:

1. Use this form to request reimbursement for services received from providers in the Davis Vision network.
2. **Only one patient's services may be claimed on this form.** Expenses for both examinations and eyewear or contact lenses can be listed on this form. Please contact Davis Vision at 1-800-77-DAVIS.
3. Be sure that all sections are completed and that you and the provider(s) have signed the form.
5. Mail completed form along with original receipts to: **Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110**.

Employee Information

**** Your Employee Identification No. is the number by which the company that sponsors your vision care benefits identifies you.***

(PLEASE PRINT CLEARLY)

Employee Name: _____ (First / Middle Initial / Last) Employee Identification No.*: _____

Mailing Address: _____ (Street / City / State / Zip)

Business Phone: ( ) _____ (Area Code) Home Phone: ( ) _____ (Area Code)

Patient Information

Patient Name: _____ (First / Middle Initial / Last)

Relationship: ☐ Employee ☐ Spouse ☐ Child DOB: _____

Provider Information

Examiner	**Dispenser (if different than provider)**
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: ____ Zip: _____	City: _____ State: ____ Zip: _____
Federal Tax I.D. Number: _____	Federal Tax I.D. Number: _____
Davis Vision Provider Number: _____	Davis Vision Provider Number: _____
Phone Number: ( ) _____	Phone Number: ( ) _____
Provider Signature: _____	Provider Signature: _____

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		$
9. Cataract Contact Lenses		$
Total		$

**Eye examination reimbursement from Davs Vision and collection of copayment (if any) from the patient will satisfy the exam as paid in full.

Important Information

1. Complete all EMPLOYEE and PATIENT areas.
2. Break down all services and costs in their respective areas.
3. Make sure the doctor and dispenser areas have been filled in and service dates have been entered.
4. Make sure this form has been signed by the EMPLOYEE.

AmeriHealth Insurance
Company of New Jersey
AmeriHealth HMO, Inc.

I certify that the information on this form is correct and authorize the Provider to release any appropriate information necessary to process this claim to plan benefit provisions.

_____ ___/___/___

Employee's or authorized person's signature **Date**