CareFirst

From the CareFirst BlueCross BlueShield family of health care plans.

FOR INTERNAL USE ONLY

Auth #: _____

Paid ☐ **Denied** ☐ **Pended** ☐

Direct Reimbursement Claim Form

Important Information:

1. Use this form to request reimbursement for services received from providers who do not participate in the Davis Vision network.
2. Expenses for both examinations and eyewear can be claimed on this form. Only services listed on this form will be considered for reimbursement.
3. **Make sure that all sections are completed, that you and the providers(s) have signed the form, and that all services, charges, and service dates have been entered. If the form is incomplete, additional information may be required. This may result in a delay of payment for eligible benefits.**
4. All claims must be submitted within one (1) year from the date of service, failure to do so will result in denial of reimbursement.
5. Please submit claim reimbursement for each patient on a separate claim form.
6. Please note that the **member's** (or employee's or authorized person's) signature is required on this form.
7. Mail completed claim form to: **Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.**
8. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage with your benefits office or call 1-800-783-5602 or visit **www.davisvision.com.** The patient is responsible for the costs of all treatment and materials provided.

Member/Employee Information

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

(PLEASE PRINT CLEARLY)

Member Name: _____ (First / Middle Initial / Last) Member 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: ☐ Member ☐ Spouse ☐ Child DOB: _____

Provider Information

Examiner

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

State License Number: _____

Phone Number: _____

Provider Signature: _____

Dispenser

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

State License Number: _____

Phone Number: _____

Provider Signature: _____

Service	Date of Service	Amount
1. Eye Examination OD ☐ MD ☐	(/ /)	$
2. Frames	(/ /)	$
3. Single Vision Lenses	(/ /)	$
4. Bifocal Lenses	(/ /)	$
5. Trifocal Lenses	(/ /)	$
6. Contact Lenses Single Vision ☐ Bifocal ☐	(/ /)	$
7. Cataract S.V. Lenses	(/ /)	$
8. Cataract Bifocal Lenses	(/ /)	$
9. Medically Necessary Contact Lenses	(/ /)	$
	Total	$

Member/Employer Certification

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim to plan provisions. Additionally, I have read and understand the Fraud Statement on the back of this form

Required

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

CL00006 10/12

FRAUD STATEMENT

Any person who knowingly and with intent to defraud and deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

In **Florida,** any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an insurance application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In **Maryland,** any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In **New Jersey,** any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In **New York,** applicants for Accident and Health Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Kentucky** and **Pennsylvania,** any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In **Tennessee,** state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.