HIGHMARK. BLUE SHIELD
An Independent Licensee of the Blue Cross and Blue Shield Association

Direct Reimbursement Claim Form

FOR INTERNAL USE ONLY
Auth #: _____
Paid ☐ **Denied** ☐ **Pended** ☐

Important Information:
1. Claims administration for your vision program is performed by Davis Vision under a contractual arrangement. 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. Please submit claim reimbursement for each patient on a separate claim form.
5. Please note that the **member's** (or employee's or authorized person's) signature is required on this form.
6. Mail completed claim form to: **Davis Vision, P.O. Box 1525, Latham, NY 12110**.
7. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage with your benefits office or call 1-800-223-4795 or visit **www.highmark.com**. The patient is responsible for the costs of all treatment and materials provided.

Member/Employee Information

**** Your Member Identification No. is the number found on your Vision Identification card.***

(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: _____

Other Vision Insurance Coverage: (name, address, policy number) _____

Provider Information

General Standard

If Lenses were prescribed, was the general standard met according to the definition below. ☐ Yes ☐ No

General Standard: Change of at least .50 diopter sphere in one eye or combined between both eyes or an increase in one line of Snellen acuity (distance or reduced near).

If no, indicate replacement reason:

☐ Loss or theft ☐ Breakage or damage
☐ Patient preference ☐ Medically related reasons, please explain or attach _____

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	(/ /)	$
2. Frames	(/ /)	$
3. Single Vision Lenses Polycarbonate ☐	(/ /)	$
4. Bifocal Lenses Progressive ☐ Polycarbonate ☐	(/ /)	$
5. Trifocal Lenses Polycarbonate ☐	(/ /)	$
6. Lenticular Lenses	(/ /)	$
7. Contact Lenses	(/ /)	$
Standard daily wear ☐ Disposables ☐	(/ /)	$
Specialty (e.g. extended wear, gas permeable, hard/soft bifocal) ☐	(/ /)	$
8. Contact Lens Fitting/follow-up Daily Wear ☐ Extended Wear ☐	(/ /)	$
9. Medically Necessary Contact Lenses	(/ /)	$
	Total	$

Member/Employee 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**

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 **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.