BlueCross BlueShield | FEPBlueVision

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 FEP BlueVision 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 **enrollee's** (or employee's or authorized person's) signature is required on this form.
6. Mail completed claim form to: **FEP BlueVision, P.O. Box 2010, Latham, NY 12110-2010**.
7. The completion and submission of this form does not guarantee eligibility for benefits. You may verify your coverage by calling 1-888-550-2583 or visit **www.fepblue.org**. The patient must pay the provider directly for all services and then submit a claim for reimbursement.

Enrollee/Employee Information

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

(PLEASE PRINT CLEARLY)

Enrollee Name: _____ Enrollee Identification No.*: _____
First Middle Initial Last

Mailing Address: _____
Street City State Zip

Business Phone: _____ Home Phone: _____
Area Code Area Code

Patient Information

Patient Name: _____
First Middle Initial Last

Relationship: ☐ Member ☐ Spouse ☐ Child DOB: _____

Does the patient have other vision coverage? ☐ Yes ☐ No

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: _____

Provider signature is required if this claim form is NOT accompanied by a detailed receipt.

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

Enrollee/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. You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer in the plan.

Required

_____ _____

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