Vision Reimbursement Form

MASS ADVANTAGE

Our plan covers vision services or materials within your service area up to an annual limit. Refer to your Evidence of Coverage for your plan's limit.

To receive reimbursement, you must submit the following:

Reimbursement Form

Your Itemized Receipt(s)

Claim Form (If provided by your Vision Provider)

Contact Information

Please submit these items to Vision Claim Processing, EyeQuest, PO Box 433, Milwaukee, WI 53201-2906 or fax to 1-888-696-9952.

1 Member Details

Title	First Name	Middle Initial	Last Name

Date of Birth (mm/dd/yyyy)	Gender: Male / Female

Mailing Address (include Apt. #)

City	State	Zip

Daytime Phone Number	Evening Phone Number

Email

Mass Advantage ID#	Policy Number

2 Provider Information

Name of Vision Provider	Provider NPI/TIN Number

Address of Services Rendered

City	State	Zip

Daytime Phone Number	Fax

3 Invoice Information

Fill in the details of each invoice being submitted with this claim.

Date of Service *(mm/dd/yyyy)*	Invoice Date	Service Rendered by Provider/Service Detail *(i.e., routine exam, glasses, contact lenses)*	Procedure Code	Invoice Amount