Vision Reimbursement Form

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 dentist)

Please submit these items to:

EyeQuest
Attention: Vision Claim Processing
PO Box 433
Milwaukee, WI 53201-2906
Fax: 1-888-696-9952

1: Member Details			
Title: Mr. / Mrs. / Ms. / Miss			
First name:	Middle initial:	Last name:	
Date of birth (mm/dd/yyyy): ____ ____ /____ ____ /____ ____ ____ ____		Gender: Male / Female	
ID number (as shown on your member ID card, 6 or 8 digits):			
Policy number (as shown on your member ID card):			
Member's full address:			Apt.:
City:		State:	Zip code:
Daytime phone: (____ ____ ____) ____ ____ ____ - ____ ____ ____ ____			
Evening phone: (____ ____ ____) ____ ____ ____ - ____ ____ ____ ____			
Email: ________________________________ @hotmail / @yahoo / @aol / @gmail / @msn / @outlook			

2: Provider Information		
Name of vision provider:		
Provider NPI/TIN number:		
Location of services rendered: Address:		Suite:
City:	State:	Zip code:
Daytime phone: (____ ____ ____) ____ ____ ____ - ____ ____ ____ ____		
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**