CSEA Employee Benefit Fund

Vision Care Direct Reimbursement Claim Form

Form must be completed and signed by the CSEA Employee Benefit Fund member. All required documentation must be attached.
Incomplete forms will be returned.

MAIL COMPLETED CLAIM TO

CSEA Employee Benefit Fund
PO Box 516
Latham, NY 12110-0516

CLAIMS ARE NOT ACCEPTED BY FAX OR EMAIL

MAJOR PLAN FEATURES

- This benefit reimburses an allowance toward the cost of a non-participating provider.
- Expenses for both eye examination and eyewear are reimbursable.

INSTRUCTIONS

- Provider may complete and sign form **or** member may attach an itemized billing statement for services rendered.

TO BE COMPLETED BY MEMBER (PLEASE PRINT)

Member's Name ______________________________ EBF ID# ______________________

Patient's Name ______________________________ DOB ______________________

Mailing Address ______________________________ Apt # ______________

City ______________________________ State __________ Zip Code __________

Daytime Phone # ______________________ Email ______________________________

TO BE COMPLETED BY PROVIDER (PLEASE PRINT)

Patient Name ______________________________ DOB ______________________

Relationship: ☐ Member ☐ Spouse ☐ Child ☐ Other: ______________________________

Provider Information

Examiner

Name ______________________________

Address ______________________________

City ______________ State ______ Zip ______

Federal Tax ID # ______________________________

Dispenser ☐ *Same as Examiner*

Name ______________________________

Address ______________________________

City ______________ State ______ Zip ______

Federal Tax ID # ______________________________

Service	Date of Service	$ Amount
1. Eye Examination		
2. Frames		
3. Single Vision Lenses (not plano)		
4. Bifocal Lenses		
5. Trifocal Lenses		
6. Contact Lenses		
7. Cataract S.V. Lenses		
8. Cataract Bifocal Lenses		

PROVIDER CERTIFICATION: ***I hereby certify that the above procedures have been completed.***

Provider's Signature ______________________________ Date ______________________

MEMBER CERTIFICATION: ***I hereby certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this according to plan benefit provisions.***

Member's Signature ______________________________ Date ______________________