☞ OUT-OF-NETWORK REIMBURSEMENT FORM

Prior to printing this form, please verify that the member/dependent is eligible for services either by visiting Vision Benefits of America's website at www.visionbenefits.com or by calling VBA's Customer Service at 1-800-432-4966. If the patient is not eligible for services, NO payment will be processed.

ALL INFORMATION MUST BE COMPLETED ON THIS FORM

INSTRUCTIONS:

❸Please attach all ***itemized*** receipts to this form. Please be certain that your itemized receipts match the information entered below.

❶Employee completes ALL parts of this form. Please complete PART 1 **BEFORE** printing this form.

❹Mail the completed form to VBA at the address listed below within 90 days of the Date of Service.

❷A separate Reimbursement Form is required for each family member.

❺All reimbursements will be sent to the employee's address on file.

PART 1: TO BE COMPLETED BY EMPLOYEE (Please complete PART 1 **BEFORE** printing the form)

EMPLOYEE'S FULL NAME	LAST 4 DIGITS OF SSN #	WORK PHONE NUMBER	HOME PHONE NUMBER

HOME ADDRESS	CITY, STATE, ZIP CODE	EMPLOYER NAME

PATIENT'S FULL NAME	RELATIONSHIP TO EMPLOYEE	EMPLOYEE DATE OF BIRTH	PATIENT DATE OF BIRTH

My signature certifies this claim is NOT related to occupational accident /injury and I authorize VBA to disclose any necessary information concerning this claim.

Sign & Date

MEMBER/EMPLOYEE SIGNATURE _____ DATE _____

PART2: USE A SEPARATE FORM FOR EACH FAMILY MEMBER

EXAM

PRACTICE NAME: _____OD _____MD	EXAM FEE:
ADDRESS:	CITY, STATE, ZIP:
PHONE NUMBER:	DATE OF EXAM: / COMMENTS:

LENSES & FRAME

DISPENSING PRACTICE NAME (IF DIFFERENT): ModernEYES Optical

ADDRESS: 1635 Manheim Pike

CITY, STATE, ZIP: Lancaster, PA 17601

PHONE NUMBER: 717-299-0925

DATE ORDERED:

INSTRUCTIONS: Attach your receipts to this form and mail to:

Vision Benefits of America
300 Weyman Road, Suite 400
Pittsburgh, PA 15236

Or Fax Form and receipts to: 412-881-7319

NOTE: Your itemized receipts must include the information indicated above. If your receipts do not reflect the information above, your claim cannot be processed.

CHARGES:

SINGLE VISION	$_____	BIFOCAL	$_____
TRIFOCAL	$_____	PROGRESSIVES	$_____
LENTICULAR	$_____	TINT	$_____
SCRATCH COAT	$_____	ANTI REFLECTIVE	$_____
PHOTOCHROMIC	$_____	POLYCARBONATE	$_____
UV COATING	$_____	ELECTIVE CONTACTS	$_____
LOW VISION AIDS	$_____	LASIK (If Covered by Plan)	$_____

MEDICALLY REQUIRED CONTACTS (attach doctor's letter) $_____

CHARGE FOR NEW FRAME (if any) $_____

TOTAL CHARGES: $_____

****** THIS FORM IS FOR SERVICES THROUGH A NON-PARTICIPATING PROVIDER ONLY ******