Vision Care Benefit Claim Sheet

Member Information			
Member Name:		Employee ID/Policy No.:	
Date of Birth:		Phone Number:	
Address:			
Patient Information (if not Member)			
Patient Name:		Relationship to Member:	
Date of Birth:			
Vision Service Details			
Date of Service:		Provider Name:	
Type of Service:	☐ Eye Exam ☐ Prescription Lenses ☐ Frames ☐ Contact Lenses ☐ Other		
Description of Service:			
Total Amount Claimed:		Currency:	

Required Documents

- ☐ Original Invoice/Receipt
- ☐ Doctorâ€™s Prescription
- ☐ Other Supporting Documents

Member Declaration

I declare that the above information is true and correct. I authorize the insurer to obtain further information if necessary.

Member Signature: _____ Date: _____