VISION REIMBURSEMENT FORM

To ensure proper reimbursement, please complete this form in full

Member Services 855-844-0626
Website www.directdentalplans.com
Fax claims to: 866-849-2038
Mail claims to: Direct Dental Vision Claims
PO Box 192
Milwaukee, WI 53201

INSTRUCTIONS: If you have paid your provider in full for vision services, please complete this form in its entirety.
REQUIRED: Upon receipt of vision services, ask your provider for a statement of billed charges and submit it with this form. Acceptable statements will include all vision codes for services rendered with diagnosis codes. Statements will also include the provider billed amount and the amount paid by the member. **Missing information may result in delayed reimbursement or denial of coverage.**

MEMBER INFORMATION			
1. COMPANY NAME	2. SUBSCRIBER ID		3. DOB
4. FIRST NAME	5. LAST NAME	6. RELATIONSHIP TO POLICYHOLDER (check one) ☐ SELF ☐ SPOUSE ☐ DEPENDENT	
7. ADDRESS	8. CITY	9. STATE	10. ZIP

OTHER VISION COVERAGE (if applicable)			
11.OTHER INSURANCE (OI) COMPANY	12.PLAN/GROUP #		13. PHONE
14. POLICYHOLDER NAME (first, last)	15. SUBSCRIBER ID	16. RELATIONSHIP TO OI POLICYHOLDER (check one) ☐ SELF ☐ SPOUSE ☐ DEPENDENT	
17. ADDRESS	18. CITY	19. STATE	20. ZIP

PROVIDER INFORMATION			
21. FIRST NAME	22. LAST NAME	23. NPI	24. PHONE
25. ADDRESS	26. CITY	27. STATE	28. ZIP

VISION SERVICES RECEIVED			
29. DESCRIPTION OF SERVICES RECIEVED	30. DATE OF SERVICE	31. BILLED AMOUNT	32. AMOUNT PAID

I certify that the above and attached information is correct and hereby authorize my vision provider to supply my employer with full information regarding services rendered, including the source of any other payments.

Name _____ Date _____

PLEASE ATTACH YOUR PROVIDER'S STATEMENT OF BILLED CHARGES MEETING THE CRITERIA DESCRIBED ABOVE