First Choice Health®

Vision Claim Reimbursement Form

Important Information:

1. Use this form to request reimbursement for services received from your vision provider.
2. Expenses for both examinations and eyewear can be claimed on this form. Only services listed on this form will be considered for reimbursement.
3. **Make sure that all sections are completed, that you and the providers(s) have signed the form, and that all services, charges, and service dates have been entered. If the form is incomplete, additional information may be required. This may result in a delay of payment for eligible benefits.**
4. Please submit claim reimbursement for each patient on a separate claim form.
5. Please note that the **member's** (or employee's or authorized person's) signature is required on this form.
6. Mail completed claim form to: **First Choice Health Administrators, PO BOX 12659, Seattle WA 98111**
7. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage with your benefits office or call (800) 430-3818 or visit **www.fchn.com**. The patient is responsible for the costs of all treatment and materials provided.

***** Please Attach Receipt to Claim Form *****

Member/Employee Information

**** Your Member Identification No. is the number by which the company that sponsors your vision care benefits identifies you.***

(PLEASE PRINT CLEARLY)

Member Name: _____ Member Identification No.*: _____
First Middle Initial Last

Mailing Address: _____
Street City State Zip

Business Phone: _____ Home Phone: _____
Area Code Area Code

Patient Information

Patient Name: _____
First Middle Initial Last

Relationship: ☐ Member ☐ Spouse ☐ Child DOB: _____ ☐ If student aged 19 or over, attach written proof of attendance at school (if required)

Are you and your spouses benefits both provided by the same agency? ☐ Yes ☐ No

Provider Information

Examiner

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

State License Number: _____

Phone Number: _____

Provider Signature: _____

Dispenser

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

State License Number: _____

Phone Number: _____

Provider Signature: _____

Service	Date of Service	Amount
1. Eye Examination		$
2. Frames		$
3. Single Vision Lenses		$
4. Bifocal Lenses		$
5. Trifocal Lenses		$
6. Contact Lenses		$
7. Cataract S.V. Lenses		$
8. Cataract Bifocal Lenses		$
9. Medically Necessary Contact Lenses		$
	Total	$

Member/Employee Certification

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim to plan provisions. Additionally, I have read and understand the fraud statement on the back of this form.

_____ _____ _____
Member/Employee or authorized person's signature **Date**