

Blue View Vision Member Reimbursement Form

DATE OF SERVICE: _____

Patient Information:

LAST NAME: _____ FIRST NAME: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ BIRTHDATE: _____

Plan Information (for subscriber):

LAST NAME: _____ FIRST NAME: _____ MI: _____

PLAN NAME: _____ SUBSCRIBER ID: _____

Provider Information:

PROVIDER NAME: _____ PHONE NUMBER: _____

PROVIDER OFFICE LOCATION: _____

METHOD OF PAYMENT: _____

PREFERRED METHOD OF REIMBURSEMENT: _____

WILL MEMBER GO BACK TO PROVIDER FOR REIMBURSEMENT? _____

Request for Reimbursement – Please Enter Amount Charged & Include itemized paid receipts.			
Exam: \$ _____	Frames: \$ _____	Lenses: \$ _____	Contact Lenses: \$ _____ (include fit and follow-up; please submit all contact related charges at the same time)
<i>If lenses were purchased, please check type:</i> <input type="checkbox"/> Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Progressive			