Vision Claim Reimbursement Form

To qualify for reimbursement you must provide all of the information requested on this form and substantiate proof of enrollment and/or payment.

First Name: ______________________________ Last Name: ____

Date of birth: ______/______/______ Telephone# ____

Address: ____

City: ____ State: __________________ Zip: ____________________

Health Plan Name (Found on your ID) ____

Health Plan ID# ______________________________________ Health Plan Group# ___________________________

Provider First Name ______________________ Provider Last Name: __________________________________

Provider Telephone# __________________________________ Provider Tax ID# (If available) _________________

Provider Address: ____

Reimbursement request - Please provide a separate claim form for each provider of service

☐ Vision

Reimbursement Guidelines:
In order to receive reimbursement, all supporting documentation must be attached to this claim form. Please include an itemized bill/statement from the provider listing the dates of service, service performed, charge and the name of the patient receiving the service. If you have other insurance, please submit the corresponding Explanation of Benefits from your insurance company.

	Date Services were Rendered MO/DAY/YEAR	Name of Provider Service	Patient Name	Amount Billed	Procedure Code	Diagnosis Code
1	___/___/___			$		
2	___/___/___			$		
3	___/___/___			$		
4	___/___/___			$		
5	___/___/___			$		
6	___/___/___			$		

Reimburse: Member ☐ Provider ☐

Email your form and documentation to: ClaimsDept@QualcareInc.com

Questions?
Contact Qualcare member services at 1-800-992-6613, Monday through Friday, 8 a.m. to 6 p.m. ET.

<u>Please read the following and then sign below</u>
I certify that all services for which reimbursement is requested were incurred by myself or my eligible dependents .
All qualfying sevices will be reimbursed as outlined in my Plan Summary Description.
My signature below affirms that all of the information listed above is complete, accurate and true, to the best of my knowledge.

Signature: ____ Date ______________________