

DAVIS VISION Direct Reimbursement Claim Form

Important Information:

1. Use this form to request reimbursement for services received from providers who do not participate in the Davis Vision network.
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: **Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.**
7. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage with your benefits office or call **1-888-393-2583** or visit **www.amerihealthexpress.com**. The patient is responsible for the costs of all treatment and materials provided.

Member/Employee Information (PLEASE PRINT CLEARLY)

Member Name:			Member Identification No:		
FIRST	MIDDLE INITIAL	LAST			
Mailing Address:					
STREET		CITY	STATE	ZIP	
Business Phone:			Home Phone:		

Patient Information

Patient Name:			Member Identification No:		
FIRST	MIDDLE INITIAL	LAST			
Relationship: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child DOB:					

Provider Information

Examiner Name:			State License No:		
Address:					
STREET		CITY	STATE	ZIP	
Phone Number:					

Provider Signature:

Dispenser Name:			State License No:		
Address:					
STREET		CITY	STATE	ZIP	
Phone Number:					

Provider Signature:

Service	Date of Service	Expense(s) Incurred
1. Eye Examination	____/____/____	\$ _____
2. Frames	____/____/____	\$ _____
3. Single Vision Lenses Polycarbonate <input type="checkbox"/>	____/____/____	\$ _____
4. Bifocal Lenses Progressive <input type="checkbox"/> Polycarbonate <input type="checkbox"/>	____/____/____	\$ _____
5. Trifocal Lenses Polycarbonate <input type="checkbox"/>	____/____/____	\$ _____
6. Contact Lenses Conventional <input type="checkbox"/> Disposable <input type="checkbox"/>	____/____/____	\$ _____
7. Cataract S.V. Lenses* Polycarbonate <input type="checkbox"/>	____/____/____	\$ _____
8. Cataract Bifocal Lenses* Progressive <input type="checkbox"/> Polycarbonate <input type="checkbox"/>	____/____/____	\$ _____
9. Medically Necessary Contact Lenses*	____/____/____	\$ _____
Contact lens evaluation and fitting	____/____/____	\$ _____



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Member Certification

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties. PROVIDERS: By signing this document, you swear or affirm that the services or materials for which this claim is being made were necessary and were, in fact, furnished.

For participants in ERISA self-funded products, references to subscriber/member shall include participants, and payments for covered services will be made by AmeriHealth New Jersey on behalf of the employer group.

I certify that the information on this form is correct and authorize the Provider to release the appropriate information necessary to process this claim to plan benefit provisions.

Member's or authorized person's signature _____

Date ____ / ____ / ____

Fraud Statement

Any person who knowingly and with intent to defraud and deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

In Florida, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an insurance application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In New Jersey, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In New York, applicants for Accident and Health Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In Kentucky and Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In Tennessee, state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Language Taglines and Nondiscrimination Notice

Language Access Services

This Notice has Important Information. This notice has important information about your application or coverage through AmeriHealth New Jersey. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-888-968-7241 TTY 711.

Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de AmeriHealth New Jersey. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-888-968-7241 TTY 711.

本通知含有您的申请或 AmeriHealth New Jersey 提供的健康保险信息等重要信息。请留意本通知内的重要日期。为了保留您的健康保险或得到收费相关支持，请在截止日期之前采取措施。相关咨询请联系我们为您提供的免费多语言信息服务，1-888-968-7241。

본 알림에는 귀하의 신청 또는 AmeriHealth New Jersey 를 통한 건강 보험과 관련된 정보와 같은 중요한 정보가 포함되어 있습니다. 본 알림에서 중요한 날짜를 확인하십시오. 지정된 마감일까지 조치를 취하셔야 건강 보험을 계속해서 유지하거나 비용 관련 지원을 받으실 수 있습니다. 관련 정보 및 지원은 해당 언어로 무료로 받으실 수 있습니다. 통역사와 상담하시려면 1-888-968-7241 로 전화해 주십시오.

Este aviso contém informações importantes. Este aviso contém informações importantes a respeito do seu formulário de solicitação ou cobertura por meio do AmeriHealth New Jersey. Procure as datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter a cobertura do seu plano de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 1-888-968-7241.

આ સૂચનામાં અગત્યની માહિતી છે. આ સૂચનામાં તમારી અરજી અથવા AmeriHealth New Jersey દ્વારા કવરેજ વિશેની અગત્યની માહિતી છે. આ સૂચનામાંની ખાસ તારીખો જુઓ. તમે તમારા આરોગ્ય કવરેજ રાખવા અથવા ખર્ચ સાથે મદદ કરવા માટે અમુક ચોક્કસ મુદતો સુધીમાં પગલાં લેવાની જરૂર છે. તમને આ માહિતી અને મદદ તમારી ભાષામાં વિના મૂલ્યે મેળવવાનો અધિકાર છે. અહીં 1-888-968-7241 કોલ કરો.

To ogłoszenie zawiera ważne informacje. To ogłoszenie zawiera ważne informacje dotyczące Państwa wniosku lub zakresu świadczeń udzielanych przez program AmeriHealth New Jersey. Powinni Państwo podjąć działania do czasu upłynięcia wyznaczonych terminów, aby utrzymać swoje ubezpieczenie zdrowotne bądź otrzymać pomoc związaną z kosztami. Mają Państwo prawo do bezpłatnej informacji we własnym języku. Proszę zadzwonić pod numer 1-888-968-7241.

Questo avviso contiene informazioni importanti . Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso AmeriHealth New Jersey. Cerca le date importanti in questo avviso. Potrebbe essere necessario un tuo intervento entro certe scadenze determinate per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere gratuitamente queste informazioni e assistenza nella tua lingua. Chiama il numero 1-888-968-7241.

يحتوي هذا الإشعار معلومات هامة. يحتوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال AmeriHealth New Jersey. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك دون أي تكلفة. اتصل بـ 1-888-968-7241.

(OVER)

Ang Paunawang ito ay may Mahalagang Impormasyon. Ang paunawang ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o saklaw sa pamamagitan ng AmeriHealth New Jersey. Tingnan ang mahahalagang petsa sa paunawang ito. Maaaring kailanganin mo na magsagawa ng hakbang bago ang mga tiyak na takdang panahon upang mapanatili ang iyong saklaw pangkalusugan o tulong sa mga gastos. May karapatan kang makakuha ng impormasyon at tulong na ito sa iyong wika nang walang gastos. Tumawag sa 1-888-968-7241.

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через программу AmeriHealth New Jersey. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры до наступления определенных предельных сроков для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-888-968-7241.

Avi sa a gen Enfòmasyon Enpòtan ladan. Avi sa a gen enfòmasyon enpòtan konsènan aplikasyon ou, oswa pwoteksyon asirans ou nan AmeriHealth New Jersey. Chèche dat kle yo ki nan avi sa a. Ou kapab bezwen aji avan sèten delè pou kontinye genyen pwoteksyon asirans sante ou oswa resevwa èd gratis. Ou gen dwa pou jwenn enfòmasyon sa a ak èd ou bezwen nan lang ou gratis. Rele 1-888-968-7241.

इस नोटिस में महत्वपूर्ण जानकारी है। इस नोटिस में आपके आवेदन या AmeriHealth New Jersey के माध्यम से बीमे के बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारीखें देखें। अपना स्वास्थ्य बीमा बनाए रखने या लागतों में मदद के लिए आपको कुछ निश्चित समयसीमाओं तक कार्रवाई करने की ज़रूरत हो सकती है। आपको यह जानकारी और सहायता अपनी भाषा में मुफ्त प्राप्त करने का अधिकार है। 1-888-968-7241 पर कॉल करें।

Thông báo này có Thông Tin Quan Trọng. Thông báo này có thông tin quan trọng về đơn xin hoặc bảo hiểm thông qua AmeriHealth New Jersey. Hãy tìm những ngày quan trọng trong thông báo này. Quý vị có thể cần thực hiện hành động trước một số thời hạn để duy trì bảo hiểm y tế hoặc trợ giúp về chi phí. Quý vị có quyền nhận được thông tin và trợ giúp bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Hãy gọi số 1-888-968-7241.

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou l'assurance médicale fournie par AmeriHealth New Jersey. Recherchez les dates clés dans le présent avis. Vous devez peut-être agir dans des délais spécifiques pour maintenir votre assurance médicale ou pour l'aide avec les coûts. Vous avez le droit d'obtenir gratuitement cette information et de l'aide dans votre langue. Appelez 1-888-968-7241.

اس نوٹس میں اہم معلومات ہیں۔ اس نوٹس میں آپ کی درخواست اور AmeriHealth New Jersey کے ذریعے احاطہ کردہ خدمات کے بارے میں اہم معلومات ہیں۔ اس نوٹس میں اہم تاریخوں پر دھیان دیں۔ آپ کو اپنے طبی تحفظ کو برقرار رکھنے یا اخراجات کے حوالے سے مدد کے لئے کچھ ڈیڈلائنوں کے اندر کارروائی کرنے کی ضرورت ہو سکتی ہے۔ آپ کو بلا معاوضہ اپنی زبان میں یہ معلومات اور مدد حاصل کرنے کا حق ہے۔ 1-888-968-7241 پر کال کریں۔

Díí saad ílínii baa hane'. Naaltsoos ni'ííníitsoozígíí éí doodago kwe'é AmeriHealth New Jersey ník'é'éstí'ígíí bína'idíílkidgo díí kwe'é hazhó'ó baa ákonínízin dooleeł. Yoolkáál yéédaá' nich'i' é'élyaaago biká'ígíí hádííí'íí. Díí níké'éstí'ígíí éí doodago béeso da bee níká a'doowołígíí bikáa'go da áat'ée dooleeł áko t'áadoo bee e'e'aahí baa yíłkaahgo tsxííłgo hasht'e dííííí ní da dooleeł. Bee ná ahóót'i'díí kót'éego yaa halne'ígíí bee níká a'doowołgo dóo t'áa nizaadk'ehjíí bee níł hodoonih t'áadoo bááh ílíní. Kojí' hodíílnih 1-888-968-7241.

この通知には、AmeriHealth New Jersey の申請や補償範囲に関するとても重要な情報が含まれています。ここに記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期限までに行動を取る必要があります。お客様は、無料でご希望の言語でのサポートや情報を入手することができます。

ぜひ 1-888-968-7241 までお電話ください。

Diese Bekanntmachung enthält wichtige Informationen. Diese Bekanntmachung enthält wichtige Informationen über Ihren Antrag bei oder Ihren Krankenversicherungsschutz durch AmeriHealth New Jersey. Beachten Sie bitte die wichtigsten Termine in dieser Bekanntmachung. Sie müssen eventuell vor bestimmten Stichtagen Maßnahmen ergreifen, um Ihren Krankenversicherungsschutz nicht zu verlieren oder finanzielle Unterstützung für diese Leistungen zu erhalten. Sie sind berechtigt, kostenlos Hilfe und weitere Informationen in Ihrer Sprache anzufordern. Bitte rufen Sie uns unter der Nummer 1-888-968-7241 an.

این اطلاعیه حاوی اطلاعاتی مهمی است. این اطلاعیه حاوی اطلاعات مهمی درباره درخواست شما یا فرارگیری تحت پوشش AmeriHealth New Jersey می باشد. به تاریخ های مهم مندرج در این اطلاعیه توجه نمایید. ممکن است لازم باشد به منظور ادامه استفاده از پوشش خدمات سلامت یا کمک در رابطه با کاهش هزینه ها، اقدامات مربوطه را تا قبل از تاریخ خاصی صورت دهید. این حق برای شما محفوظ است که بدون نیاز به پرداخت هر نوع هزینه، اطلاعات مربوطه را به زبان خود دریافت نمایید. با شماره تماس 1-888-968-7241 تماس بگیرید

Nondiscrimination Notice & Notice of Availability of Auxiliary Aids & Services

AmeriHealth New Jersey complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AmeriHealth New Jersey does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AmeriHealth New Jersey:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact our Civil Rights Coordinator. If you believe that AmeriHealth New Jersey has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You have four ways to file a grievance:

- By mail :
AmeriHealth New Jersey
Attn: Civil Rights Coordinator
1901 Market Street
Philadelphia, PA 19103
- By phone: 888-377-3933 (TTY:711)
- By fax: 215-761-0245
- By email: CivilRightsCoordinator@amerihealth.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.js> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.