CLAIM FORM FOR PARTICIPANT REIMBURSEMENT

Subscriber Name: _____

Mailing Address: _____ _____

Patient Name: _____

Employer: _____

Participant ID#: _____ Email Address: _____

Date(s) of Service	Type of Expense (i.e., frames, lens)	Dollar Amount
		$
		$
		$
		$
		$
		$

NOTE: A detailed receipt needs to be attached in order for the claim to be processed.

Employee Signature: _____ Date: _____

I certify that the expenses for reimbursement requested were incurred by me (and/or my spouse and/or eligible dependents) and to the best of my knowledge and belief, are eligible for reimbursement under my Health Plan.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claims containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.