# CSEA Employee Benefit Fund
# Vision Care Direct Reimbursement Claim Form

CSEA NEW YORK Employee Benefit Fund

Form must be completed and signed by the CSEA Employee Benefit Fund member. All required documentation must be attached.
**Incomplete forms will be returned.**

## MAIL COMPLETED CLAIM TO

**CSEA Employee Benefit Fund**
**PO Box 516**
**Latham, NY 12110-0516**

***CLAIMS ARE NOT ACCEPTED BY FAX OR EMAIL***

## MAJOR PLAN FEATURES

- This benefit reimburses an allowance toward the cost of a non-participating provider.
- Expenses for both eye examination and eyewear are reimbursable.

## INSTRUCTIONS

- Provider may complete and sign form **or** member may attach an itemized billing statement for services rendered.

## TO BE COMPLETED BY MEMBER (PLEASE PRINT)

Member's Name _____ EBF ID# _____

Patient's Name_____ DOB _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip Code _____

Daytime Phone # _____ Email _____

## TO BE COMPLETED BY PROVIDER (PLEASE PRINT)

### Provider Information

**Examiner**

Name _____

Address _____

City _____ State _____ Zip _____

Federal Tax ID # _____

**Dispenser** ☐ *Same as Examiner*

Name _____

Address _____

City _____ State _____ Zip _____

Federal Tax ID # _____

| Service | Date of Service | $ Amount |
|---|---|---|
| 1. Eye Examination | | |
| 2. Frames | | |
| 3. Single Vision Lenses (not plano) | | |
| 4. Bifocal Lenses | | |
| 5. Trifocal Lenses | | |
| 6. Contact Lenses | | |
| 7. Cataract S.V. Lenses | | |
| 8. Cataract Bifocal Lenses | | |

**PROVIDER CERTIFICATION:** ***I hereby certify that the above procedures have been completed.***

Provider's Signature _____ Date _____

**MEMBER CERTIFICATION:** ***I hereby certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this according to plan benefit provisions.***

Member's Signature _____ Date _____