iCare HEALTH SOLUTIONS
a vsp vision company

MEMBER REIMBURSEMENT CLAIM FORM

Important Information

- This form is used to request reimbursement for services received from providers who do not participate in the vision network. Completion of this form does not guarantee reimbursement. The member's health plan must allow coverage for services and materials provided by out-of-network providers, and the member must be eligible on the date of service.
- Expenses for eye exams and eyewear can be claimed on this form. Only services listed on this form will be considered for reimbursement. Please submit a separate form for each patient.
- Make sure that all sections are completed and that you have signed the form. If the form is incomplete, additional information may be required, which may result in a delay of payment for eligible benefits.
- The itemized receipt of payment, preprinted with the provider's name and address, must be submitted with this form.
- **Please submit completed forms and a copy of the itemized receipt to our address: P.O. Box 527271 Miami, FL 33152**
- For assistance, please call 855-373-7627

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MEMBER INFORMATION

Member First Name	Member Middle Name	Member Last Name

Date of Birth	Member Identification Number	Health Plan Name
- -		

Mailing Address	Primary Contact Number	Select Type
		☐ Home ☐ Cell ☐ Business

City	State	Zip	Alternative Contact Number	Select Type
				☐ Home ☐ Cell ☐ Business

PATIENT INFORMATION

☐ Select if the same

Patient First Name	Patient Middle Name	Patient Last Name

Date of Birth	Relationship
- -	☐ Member ☐ Spouse ☐ Child

PROVIDER INFORMATION

	☐ Select if the same
Provider Name	Eyewear Dispenser
Address	Address

City	State	Zip	City	State	Zip

Phone Number	Phone Number

Service	Date of Service	Amount
1. Eye Examination	- -	$
2. Frames	- -	$
3. Single Vision Lenses	- -	$
4. Bifocal Lenses	- -	$
5. Trifocal Lenses	- -	$
6. Contact Lenses	- -	$
7. Cataract S. V. Lenses	- -	$
8. Cataract Bifocal Lenses	- -	$
9. Medically Necessary Contact Lenses	- -	$
	Total	$

MEMBER CERTIFICATION

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim to plan provisions. Additionally, I have read and understand the fraud statement below.

Member or authorized person's signature	Date

FRAUD STATEMENT: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. (Note: Depending on the state where you live, additional penalties may apply.)