Highmark Delaware

VISION PLAN
CUSTOMER CLAIM FORM

- Please read the instructions on the reverse side before completing this form.
- After completion, please mail this form AND your itemized bills to:

Highmark Blue Cross Blue Shield Delaware
P.O. Box 8830
Wilmington, DE 19899-8830

1. PATIENT INFORMATION (Please Print)

Sex: ❑ Male ❑ Female

Patient's First Name M.I. Last Name

Patient's Relationship to Customer

Patient's Date of Birth—Month, Day, Year

Patient's Telephone Number—Include Area Code

2. CUSTOMER INFORMATION (Please Print)

Customer's First Name M.I. Last Name

Address—Street, Apt. #, Route

Address—Continued

City State Zip Code

Identification Number

Account Number

3. If you, your spouse, or dependent children insured under this benefit plan are also covered under any other health insurance plan, please indicate:

Name of Insured Person

Policy Number

Name of Other Health Insurance Company

Address of Other Health Insurance Company

4. Please indicate the category(ies) for which you are submitting receipts by listing charges separately.

Vision exam .....$ _____
Frames .....$ _____
Single vision lenses .....$ _____
Bifocals .....$ _____
Trifocals .....$ _____
Hard or soft contact lenses .....$ _____
Disposable contact lenses.....$ _____
Total Charges .....$ _____

For charges, please submit an **ITEMIZED RECEIPT** that includes:

- Patient's name
- Provider's name
- Date of Service
- Itemized breakdown of exam and materials charges

5. I certify that all of the information provided by me, including statements and/or bills listed above, is correct and complete to the best of my knowledge and that I am claiming benefits for charges incurred by the patient named above.

Customer's Signature: **Date**

Delaware law requires us to inform you that any person, who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony.

INSTRUCTIONS

Important—Please read these instructions before completing the reverse side.

This Vision Plan is a customer reimbursement program. Please use this claim form when you send us itemized bills for reimbursement.

About Vision Plan Benefits
If you have questions about what services are covered by your Vision Plan, please review your benefits handbook.

When to File a Claim
You can file a claim for Vision Plan benefits anytime during the year. We recommend that you file claims soon after you receive services covered by your Vision Plan. Waiting to file claims until the end of the year can cause payment delays. Also, you must send us claims within 2 years of the date you receive covered services. We can not reimburse claims we receive after the 2 year deadline.

How to File a Claim

1. Answer all questions on the other side of this form.
   Patient information pertains to the person who received Vision Plan services.
   Customer information pertains to the employed person covered under the account benefit plan.

2. Submit a separate form for EACH family member who receives services covered by the Vision Plan.

3. Attach itemized receipts completed by the provider. Your original itemized bills will not be returned. You may want to keep copies for your records.

   The following are not acceptable as proof for incurred charges:
   a. canceled checks
   b. cash register receipts
   c. statements prepared by the person(s) submitting this form.

4. Use this space to give any additional details which may be helpful in processing this request.

5. Call one of these telephone numbers for questions or information regarding your Vision Plan:

   302.429.0260 or **800.633.2563**