

VISION REIMBURSEMENT CLAIM FORM



Employee Instructions:

1. Vision reimbursement form must be complete and clear. **Failure to answer any questions or provide proper documentation may delay payment.**
2. All receipts must include: The patient name, the date that the service occurred, specific service obtained (frames, lenses, exam) with the corresponding HCPCS or CPT code and the amount for each charge.
3. Attach paid receipts. **Cancelled/Copied checks will not be accepted.**

Participant Information	
Employer: _____	
Employee Name: _____	Date of Birth: ____ / ____ / ____
Street Address: _____	<input type="checkbox"/> Check if new address
City: _____	State: _____ Zip Code: _____
Email Address: _____	<input type="checkbox"/> Check if new email address
<p>To the best of my knowledge and belief, this Vision Reimbursement Claim form is complete and true. I certify that the member has received the services described above on the date of service indicated and that the expenses qualify as a valid vision service under the Plan. If the expense is for my spouse or dependent, I certify that the person's receipt(s) meets the definition of dependent/spouse in the Plan. I certify that I have not been reimbursed previously for these expenses under any other Flexible Spending Account or Vision Benefit Plan. I understand that these expenses may not be used to claim any federal income tax deduction or credit.</p>	
Participant Signature (Required) _____	Date: _____

Name of Person Receiving Service	Relationship to Employee	Reimbursement Requested
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

How to Submit Claims		
Electronically: Email: claims@varipro.com	By FAX: FAX Number: 616 285-9965 Number of Pages: _____	By Mail: Varipro 5300 Patterson Ave SE, Suite 150 Grand Rapids, MI 49512

Customer Service: 800-732-3412