



Vision Plan Claim Reimbursement Form

Please complete the employee and patient information

Today's Date	Date of Service
Employee's Name	Employee's Identification Number

Address where check should be mailed

Street Address

City	State	ZIP
Patient's Name	Patient's Relationship to Employee (check one) <input type="radio"/> Self <input type="radio"/> Dependent	Patient's Date of Birth

Please complete services and materials received. You must provide the costs paid. Costs paid must match submitted receipt(s).

Please Note: Receipts must be submitted together at the same time for services and materials purchased (even if purchased on different dates) to receive reimbursement. You will receive a one-time reimbursement based on your service frequency in your employer's vision care plan.

Exam

Eye / Vision Exam Paid: \$

Complete below for glasses	Complete below for contacts
Glasses	Contacts
<input type="radio"/> Frames Paid: \$	<input type="radio"/> Contact Fitting / Exam Paid: \$
Glasses Lens Type (check only one)	<input type="radio"/> Contact Lenses Paid: \$
<input type="radio"/> Single-Vision Lenses Paid: \$	Note: Contact fitting fees must accompany contact lenses purchased.
<input type="radio"/> Bi-focal Lenses Paid: \$	
<input type="radio"/> Tri-focal Lenses Paid: \$	If service(s) received from an in-network provider, please include provider's National Provider Identification Number (NPI):
<input type="radio"/> Lenticular Lenses Paid: \$	
Total Paid: \$ Paid: \$	
Employee Signature	Date

Please return this form with a copy of your paid, itemized receipt to:

Centrix Benefit Administrators:
Claims Department
P.O. Box 212199
Chula Vista, CA 91921
Fax: (619) 220-9003
Or email to: support@centrixba.com

Questions? You can call our Customer Service Department at (800) 585-5965