IBEW District 8

Vision Reimbursement Claim Form
PO Box 99416
Troy, MI 48099
Phone: (844) 989-2321 or (314) 656-1085, Fax: (314) 720-0514

Information Required for Processing:

- ✓ Itemized bill reflecting proof of payment
- ✓ Provider's name, address, phone number and Tax ID
- ✓ Procedure Code (CPT) and Diagnosis Code (ICD)
- ✓ Cash register receipts alone are not acceptable

Member's Name:
_____

Member's DOB:_____Alt ID or Last 4 SSN: _____

Address:
_____

Phone Number: (Home)_____(Work)_____(Cell) _____

Patient Name:_____Patient's DOB:_____

Provider's Name:_____Tax Id:
_____

Provider's Address:
_____

Provider's Phone #:
_____

CPT:_____
ICD: _____

Date of Service Provider Billed Amount

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Member's Signature:_____Date: _____