SUPERIOR VISION

DeltaVision

Reimbursement Claim Form

Use this form for reimbursement of services received from an out-of-network provider or when you have utilized an in-store sale or promotion from an in-network provider.

Member Information (Please print clearly)

Member Name	Daytime Phone ( )	Evening Phone ( )	
Mailing Address	City	State	Zip
ID Number	Plan Name		

Patient Information

Patient Name	Date of Birth / /	Authorization Number* * If known

Claim Information

Date of Service: ______________

Exam: $____________________

Frame: $____________________

Single Vision Lenses: $_____

Bifocal Lenses: $_____

Trifocal Lenses: $_____

Progressive Lenses: $_____

Contacts: $_____

Contact Lens Fitting Exam: $_____

Extra Ad-Ons: $_____

Other:________________ $_____

Is the provider an in-network provider? ☐ Yes ☐ No

Provider Name_____________________ Phone Number______________

If you saw an in-network provider:

Are you applying for reimbursement after using an in-store sale or promotion? ☐ Yes ☐ No

If you see an in-network provider but choose to take advantage of a sale, coupon, or other in-store special, the provider may require that you pay in full and then submit your receipt to Superior Vision for reimbursement at the out-of-network rates.

If you paid in full for your service, please provide a brief explanation as to why your provider did not bill us on your behalf.

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Mail or fax a copy of the itemized invoice or receipt imprinted with the provider's name and address along with this form to the contact information below. Please retain the original for your records.

Superior Vision, Administrators
Attn: Claims Processing
P.O. Box 967
Rancho Cordova, CA 95741
Fax: 916.852.2277

Questions? Please contact our Customer Service department at contactus@superiorvision.com or (800) 507.3800.