Heritage vision plans

Claim Form - Direct Member Reimbursement

INSTRUCTIONS:

Mail this form along with related receipts to:

Heritage Vision Plans
One Woodward Ave, Suite 2020
Detroit, MI 48226
eligibility@heritagevisionplans.com

EMPLOYEE INFORMATION:

Employer Name / Group:	
Employee Name:	Gender: ☐ Male ☐ Female
Member ID or Last 4 of SSN:	Date of Birth:

ADDRESS:

Street Address:		Apt. or Unit #:
City:	State:	Zip:
Phone:	Other Phone:	

PATIENT INFORMATION:

Name of Patient Serviced:	Date of Birth:
Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other	Gender: ☐ Male ☐ Female

SERVICE INFORMATION:

Date of Service:		
Place of Service:		
Street Address:		Phone:
City:	State:	Zip:

SERVICES RECEIVED: (Please check all that apply and include amount paid for each)

☐ Exam	Provider Type: ☐ OD ☐ MD	$
☐ Lenses	Lens Type: ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Progressive ☐ Other	$
☐ Lens Options	Options: ☐ Tint ☐ Other	$
☐ Frame	Frame Type: ☐ Standard ☐ Premium	$
☐ Contacts	Contact Type: ☐ Elective/Cosmetic (Includes Disposable) ☐ Medically Necessary (Requires Pre-approval)	$
☐ Contact Fit		$
Total		$

The information supplied by me or on my behalf is true and accurate to the best of my knowledge.

Signature: Date:

HERITAGE VISION PLANS USE ONLY	Received:	Approved:	Initials: