St Luke's™ Health Plan

Vision Claim Reimbursement Form

Important Information:

1. Use this form to request reimbursement for services received from your vision provider.
2. Expenses for both examinations and eyewear can be claimed on this form. Only services listed on this form will be considered for reimbursement.
3. Make sure that all sections are completed, that you and the providers(s) have signed the form, and that all services, charges, and service dates have been entered. If the form is incomplete, additional information may be required. This may result in a delay of payment for eligible benefits.
4. Exclusions not qualified for reimbursement include the following non-prescription eyewear: sunglasses, safety glasses or use for cosmetic purposes.
5. Please submit claim reimbursement for each patient on a separate claim form, **and attach prescription**.
6. Please note that the member's (or employee's or authorized person's) signature is required on this form.
7. Mail completed claim form to: St. Luke's Health Plan, PO Box 1739, Boise, ID 83702-5809
8. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage with your benefits office or call **833-840-3600** or visit **stlukeshealthplan.org** The patient is responsible for the costs of all treatment and materials provided.

***** Please Attach Prescription and Receipt to Claim Form *****

Member/Employee Information

** Your Member Identification No. is the number by which the company that sponsors your vision care benefits identifies you.*

(PLEASE PRINT CLEARLY)

Member Name: _____ (First / Middle / Last) Member Identification No.*: _____

Mailing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Business Phone: _____ (Area Code) Home Phone: _____ (Area Code)

Patient Information

Patient Name: _____ (First / Middle / Last)

Relationship: ☐ Member ☐ Spouse ☐ Child DOB: _____ If student aged 19 or over, attach written proof of attendance at school (if required)

Are you and your spouses benefits both provided by the same agency? ☐ Yes ☐ No

Provider Information

Examiner

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

State License Number: _____

Phone Number: _____

Dispenser

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

State License Number: _____

Phone Number: _____

Provider Information (continued)

	Service	Date of Service (/ /)	Amount
1.	Eye Examination	( )	$
2.	Frames	( )	$
3.	Single Vision Lenses	( )	$
4.	Bifocal Lenses	( )	$
5.	Trifocal Lenses	( )	$
6.	Contact Lenses	( )	$
7.	Cataract S.V. Lenses	( )	$
8.	Cataract Bifocal Lenses	( )	$
9.	Medically Necessary Contact Lenses	( )	$
		Total	$

Member/Employee Certification

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim to plan provisions. Additionally, I have read and understand the fraud statement on the back of this form.

Member/Employee or authorized person's signature **Date**