Vision Reimbursement Claim Form

Complete the following and attach itemized statements (cash register receipts cannot be accepted).

1. Employer/Group Name_____

2. Employee's Name: Last:_____ First:_____

3. Employee's Mailing Address:

   _____

   City _____ State _____ Zip _____

4. Phone Number: _____

5. Patient's Name: Last_____First: _____

6. Patient's Date Of Birth: _____

7. Does the patient have other vision coverage?: Yes☐ No☐
   - Name of vision insurance company:_____
   - Policy Number:_____
   - Effective Date:_____

8. Payment for the attached claims should be made to:

   Employee☐ Provider☐

I authorize the release of any medical information necessary to process the claim and request payment of benefits to either myself or to the provider as stated above. I certify the above information to be true to the best of my knowledge. I also understand that any misrepresentation may be cause for dismissal and/or nonpayment of claims.

9. Employee Signature:_____Date:_____

Mail completed form to: **Samera Health**
PO Box 126, Smithfield UT 84335

You may also fax or email your claim as follows:
Fax claims to: 435-563-4035 | Email: claims@samerahealth.com