VISION REIMBURSEMENT FORM

To ensure proper reimbursement, please complete this form in full.

Member Services:
855-844-0626

Website:
www.directdentalplans.com

Email:
helpdesk@directdentalplans.com

Mail Claims To:
Direct Dental Claims
PO Box 192
Milwaukee, WI 53201

INSTRUCTIONS: If you have paid your provider in full for Vision services, please complete this form in its entirety.
REQUIRED: Ask your provider for a statement of services which should include; procedure code, quantity, date of service and amount paid. Your provider can assist you with completion of the form. **Proof of payment is required.**
To ensure proper reimbursement, please complete this form in full. Claim forms missing information cannot be processed.

MEMBER INFORMATION	
Group Name:	
Patient Name:	**Insurance ID Number:**
Patient Phone Number:	**Date of Birth:**
Address: (Street, City, State, ZIP Code)	
PROVIDER INFORMATION	
Provider Number (Internal use only) **72113**	Location Number (Internal use only) **55050**

VISION SERVICES RECEIVED

Check Services	Code	Item Description	Quantity	Date of Service	Cost
☐	92002	Vision Exam			
☐	V2020	Frames			
☐	V2100	Lenses, Single Vision			
☐	V2200	Lenses, Bifocals			
☐	V2300	Lenses, Trifocal			
☐	V2750	Anti-Reflective coating/glare			
☐	V2500	Contacts			

If you received additional services that are not noted above, please record them below

Check Services	Code	Item Description	Quantity	Date of Service	Cost
☐					
☐					
☐					

I certify that the above and attached information is accurate and hereby authorize my provider to supply any information regarding the services rendered, including the source of any other payments.

Name/Signature _____ Date _____

***PLEASE ATTACH YOUR PROVIDER'S STATEMENT OF BILLED CHARGES MEETING THE CRITERIA DESCRIBED ABOVE**