Member Reimbursement Form - Vision

Please print clearly, complete all applicable sections and sign. **Proof of payment is required.** Please submit all documents to: Advantek Benefit Administrators Attn: Claims Department PO Box 45007 Fresno, CA 93718 or email: claims@advantekbenefit.com

Subscriber ID#	Subscriber Name (Last, First, Middle)		
Patient Name (Last, First, Middle)			Date of Birth MM/DD/YYY
Home Address		Relationship to Subscriber (Please circle one) Self / Spouse / Dependent / Other	
City	State	Zip	Phone

Provider Name		Provider Tax ID Number	
Provider Address			
City	State	Zip	Phone

Date of Service	Place of Service	Quantity	Vision Service / Material Description	Amount Charged	Amount Paid
1.					
2.					
3.					

Is the patient covered by another insurance plan? Yes or No **If yes**, please provide the information below.

Name of person carrying other Insurance (Last, First)		Date of Birth
Name of other insurance carrier	Policy Number	Employer Name

Assignment of Benefits:

I request that payment of authorized medical benefits is made on my behalf directly to the provider of all service(s) furnished to me.

Signature ________________________________

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Subscriber Signature___________________________________ **Date**____________________