Member Reimbursement Claim Form

Superior Vision
Our Members. Our Mission.

Subscriber Information

Subscriber Name	Daytime Phone ( )	Evening Phone ( )	
Mailing Address	City	State	Zip
Subscriber ID Number	Name of Employer		

Patient Information

Patient Name	Date of Birth ____/____/____	Authorization Number	Full Time Student* ☐ Yes ☐ No * Verification may be required

Claim Information

Exam: $ Frame: $ Date of Service: _____	Single Vision Lenses: $ Bifocal Lenses: $ Trifocal Lenses: $ Progressive Lenses: $ Extra Ad-Ons: $	Contacts: $ Contact Fitting Fee: $ Other: $

1. Is the Provider of Service a member of the Superior Vision Network? ☐ Yes ☐ No

Provider Name_____ Phone Number_____

If No, you may disregard the remaining questions.

2. If you answered **Yes to question 1**, are you applying for Reimbursement after using an In-store Sale or Promotion?
☐ Yes ☐ No

3. If you answered **Yes to question 2**, please see our website www.superiorvision.com or call our Customer Service Department at 1-800-507-3800 for information regarding your reimbursement.

4. If you answered **No to question 2**, please note Superior Vision Network Providers should only collect for Copayments and/or Non-covered items at the time of service. The Network Provider will bill Superior Vision directly for all covered services. If you paid for all charges in full at the time of service please give a brief explanation as to why the Network Provider did not bill Superior Vision on your behalf (you may write on the back of this form if necessary).

Mail or Fax original itemized invoice or receipt imprinted with the provider's name and address along with this form to:

Superior Vision Services, Inc. Attn: Claims Processing
P.O. Box 967
Rancho Cordova, CA 95741
Or FAX: 1-916-852-2277

Questions? Please call our Customer Service Department at 1-800-507-3800