



Superior Vision Services, Inc.

Member Reimbursement Claim Form

Subscriber Information

This top section must be completed in full

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

| | | | |
|--------------|---------------------------------|----------------------|--|
| Patient Name | Date of Birth ____/____/____ | Authorization Number | Full Time Student* <input type="checkbox"/> Yes <input type="checkbox"/> No * Verification may be required |
|--------------|---------------------------------|----------------------|--|

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

Customer Service Department: 1-800-507-3800