First Benefit Administrators

EMPLOYER NAME: _____

VISION CLAIM FORM

LAST NAME _____ FIRST NAME _____ MI ____ ID Number _____

DAYTIME PHONE ( ) _____ ☐ Check box if address has changed

ADDRESS _____ CITY_____

STATE_____ ZIP CODE_____ E-MAIL _____

REQUIRED – COMPLETE ALL SECTIONS

In order to receive reimbursement, supporting documentation must be attached. Please include an itemized bill from the provider listing exact dates of service (balance forward statements not acceptable), services performed, patient's name and cost. If other coverage, an Explanation of Benefits (EOB) from your insurance company listing service dates, service performed and cost. Please retain a copy of this claim form and supporting documentation for your records, as we are unable to return original documents to you.

SERVICE DATE	PATIENT'S NAME	COST	SERVICE PROVIDERS	DESCRIPTION
		$ _____		
		$ _____		
		$ _____		
		$ _____		
		$ _____		
	TOTAL	$ _____	FOR OFFICE USE ONLY ☐ Notified of Ineligible Expense Date:_____	

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- They were incurred for services or supplies received by my eligible dependents or me under the plan.
- They were for services or supplies furnished on or after the effective date of my employee.
- I have not been reimbursed for these expenses in any other way or from any other source.

_____ _____

Participant's Signature Date

NOTE: *Deadline for filing current year claims for reimbursement is 90 days after the end of the Plan year*

PLEASE MAIL OR FAX THE COMPLETED SIGNED FORM TO: FIRST BENEFIT ADMINISTRATORS, INC
9455 Koger Blvd N. Suite 100, St. Petersburg, FL 33702 Phone: 727.530.4144 ◊ Fax: 727-532-9602
www.firstbenefitadmin.com