

Mail Reimbursement Form to: CBA Blue P.O. Box 2365 South Burlington, VT 05407-2365 Phone: 888-222-9206 Fax: 802-846-2755

APPLICATION FOR VISION MATERIALS OR OUT-OF-NETWORK PROVIDER REIMBURSEMENT CLAIM FORM:

This claim form must be accompanied by a copy of an itemized bill on provider letterhead to be eligible for plan reimbursement. You must complete each of the sections below.

SECTION I: EMPLOYEE INFORMATION					
NAME		SEX			DATE OF BIRTH
		MALE	FEMAL	LE	
STREET ADDRESS		HOME PHO	ONE NO.		
CITY, STATE, ZIP CODE		EMPLOYEE CARDHOLD NUMBER			
SECTION II: PATIENT INFORMATION					
NAME	DATE OF BIRTH		SEX		RELATION
			MALE	FEMALE	SELF SPOUSE DEPENDENT
					OTHER
STREET ADDRESS			HOME PHO	NE NO.	
CITY, STATE, ZIP CODE					
SECTION III: BENEFIT TYPE					
SELECT FROM THE BELOW:					
☐ FRAMES ☐ LENSE(S) ☐ CONTACT LENSES ☐ FITTING ADJUSTMENT ☐ EXAM					
AUTHORIZATION TO OBTAIN INFORMATION:					
TO ALL PHYSICIANS, MEDICAL PROFESSIONALS, HOSPITALS, CLINICS, OTHER HEALTH CARE PROVIDERS, GROUP POLICYHOLDERS, INSUR-					
ANCE SUPPORT ORGANIZATIONS, AND OTHER PERSONS WHO HAVE INFORMATION ABOUT THE PATIENT:					
I AUTHORIZE YOU TO GIVE CBA BLUE ITS REINSURERS, OR ITS AGENTS: A) ALL INFORMATION YOU HAVE AS TO ILLNESS, MEDICAL HISTORY,					
DIAGNOSIS, TREATMENT, AND PROGNOSIS WITH RESPECT TO ANY PHYSICAL OR MENTAL CONDITION OF THE PATIENT; B)ALL EMPLOY-					
MENT INFROMATION YOU HAVE ABOUT THE PATIENT; AND C) ANY OTHER INFORMATION YOU HAVE ABOUT THE PATIENT WHICH CBA BLUE BELIEVES IT NEEDS TO DETERMINE THAT THE PATIENT IS ELIGIBLE FOR BENEFITS UNDER A CONTRACT ADMINISTERED BY CBA BLUE					
AND/OR FOR ANY OTHER PURPOSE WHICH RELATES TO THE CONTRACT.					
ANY BENEFITS PAYABLE ARE DUE TO THE (CHECK ONE): PROVIDER MEMBER					
SIGNATURE OF EMPLOYEE	DATE			•	