CBA Blue
An independent licensee of the Blue Cross and Blue Shield Association.

Mail Reimbursement Form to:
CBA Blue
P.O. Box 2365
South Burlington, VT 05407-2365

Phone: 888-222-9206
Fax: 802-846-2755
E-mail: service@cabluevt.com

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 MALE FEMALE	DATE OF BIRTH
STREET ADDRESS	HOME PHONE NO.	
CITY, STATE, ZIP CODE	EMPLOYEE CARDHOLD NUMBER	

SECTION II: PATIENT INFORMATION			
NAME	DATE OF BIRTH	SEX MALE FEMALE	RELATION SELF SPOUSE DEPENDENT OTHER
STREET ADDRESS		HOME PHONE 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, INSURANCE 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 EMPLOYMENT 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