Superior Vision®
Our Members. Our Mission.

Member Reimbursement Claim Form

Use this form for reimbursement for services received from an out-of-network provider, or when youôve utilized an in-store sale or promotion from an in-network provider.

Subscriber Information ***(Please print clearly)***

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

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

Is the provider an in-network provider? ☐ Yes ☐ No

Provider Name _____ Phone Number _____

If you saw an in-network provider:

Are you applying for reimbursement after using an in-store sale or promotion?

☐ Yes ☐ No

If you see an in-network provider but choose to take advantage of a sale, coupon, or other in-store special, the provider may require that you pay in full and then submit your receipt to Superior Vision for reimbursement at the out-of-network rates.

If you have co-pays, these are paid to your in-network provider at the time of your visit. You are also responsible for paying for any services or materials that are not covered or that exceed your benefit plan coverage. If you paid in full for your service, please provide a brief explanation as to why your provider did not bill us on your behalf.

Mail or fax a copy of the itemized invoice or receipt imprinted with the providerôs name and address along with this form to the contact information below. Please retain the original for your records.

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

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