Imperial Valley Schools Joint Powers Authority

P.O. Box 5809
Fresno, CA 93755
(866) 777-1320

OUT OF NETWORK VISION CARE CLAIM FORM

This form must be completed in **FULL** to be considered for payment. Upon completion, attach receipt and mail to ASi at the address listed above.

PART 1 **TO BE COMPLETED BY ELIGIBLE EMPLOYEE**

Please print last name _____ First _____ MI _ Birthdate _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number (_____) _____ Member ID No. _____

Name of present or last employer _____

PAYMENT TO BE REMITTED TO: ☐ EMPLOYEE ☐ PROVIDER

Claim is made for: (Check one) ☐**Self** ☐ **Dependent**

Dependent Name _____ Member ID No. _____ Relationship _____ DOB _____

WERE ANY EXPENSES COVERED BY WORKER'S COMPENSATION OR ANY OTHER VISION PLAN? ☐ No ☐ Yes**

****If YES, please provide name, address, phone number, and Policy No. of OTHER Plan/Group.**

Also attach a copy of the Explanation of Benefits.

I CERTIFY THAT THE ABOVE AND ATTACHED INFORMATION IS TRUE AND CORRECT.

Eligible employee's signature _____ Date _____

PART 2 **TO BE COMPLETED BY PROVIDER**

Provider's SSN or TIN: _____ Date Of Service: _____

Provider Name: _____ Degree _____

Provider Address _____ City _____ State _____ Zip Code _____

Provider Telephone Number (_____) _____ Provider's Signature _____

	Examination $		Tints & Coatings $
	Refraction $		Transitions $
☐ one ☐ two	Lenses-Single $		Progressive $
☐ one ☐ two	Lenses-Bifocal $		Other (describe) $
☐ one ☐ two	Lenses-Trifocal $		$
☐ one ☐ two	Contact Lenses $		$
☐ one ☐ two	Frame $		$

TOTAL CHARGES $ _____

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