

vision claim form

PHS - Alaska



Benefits are as shown in your Summary Plan Description (SPD), and all covered services are subject to the specific conditions, duration limitations and all applicable maximums as noted in your SPD. **The submission of this form does not guarantee reimbursement.**

Please attach any bill(s) for services received from a licensed eye care provider, as defined in your SPD. Bill(s) must be suitable for insurance billing purposes and must include the following:

- Date of service
- Physician/provider name, address and tax identification number
- Diagnosis and service codes
- Charges for each service

Cash register or credit card receipts are **not** suitable for insurance billing purposes and **will not** be accepted for reimbursement.

MEMBER & SUBSCRIBER INFORMATION		
MEMBER'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	MEMBER'S DATE OF BIRTH	MEMBER I.D. NO.
SUBSCRIBER'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)		SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

Please check all that apply:

Vision exam (less \$45 copay*): _____
amount paid

Eyewear (lenses/frames): _____
amount paid

***Please note:** If you are covered under the PHS Alaska medical plans administered by PHP, your vision exam is covered annually at 100% and will be paid under your medical plan first.

Submit this completed form to:

Providence Health Plans

P.O. Box 3125

Portland OR, 97208-3125

If you have any questions or concerns, please contact your Customer Service team at 503-574-7500 or 1-800-878-4445.