

General Motors Corporation

IUE-CWA and Non-Represented Enrollees Vision Coverage

Out-of-Network Claim Form

| | | |
|-------------------------------|---------------------------------|---------------------------------|
| FOR INTERNAL USE ONLY | | |
| Auth #: | _____ | |
| Paid <input type="checkbox"/> | Denied <input type="checkbox"/> | Pended <input type="checkbox"/> |

Instructions:

1. Use this form to request reimbursement for services received from providers who do not participate in the Davis Vision network.
2. Expenses for both examinations and eyewear can be claimed on this form. Only services listed on this form will be considered for reimbursement.
3. **Make sure that all sections are completed, that you and the providers(s) have signed the form, and that all services, charges, and service dates have been entered. If the form is incomplete, additional information may be required. This may result in a delay of payment for eligible benefits.**
4. Please submit claim reimbursement for each patient on a separate claim form.
5. Please note that the **member's** (or employee's or authorized person's) signature is required on this form.
6. Mail completed claim form to: **Vision Care Processing Unit, P.O. Box 1490, Latham, NY 12110.**
7. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage with your benefits office or call 1-888-GM-EYES0 or visit www.davisvision.com. The patient is responsible for the costs of all treatment and materials provided.
8. **FOR PATIENTS RESIDING IN TN ONLY:** Tennessee state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee Information * Your Employee Identification No. is the number by which the company that sponsors your vision care benefits identifies you.

Employee Identification No.*: _____

Employee Name: _____

First Middle Initial Last

Mailing Address: _____

Street City State Zip

Business Phone:(_____) _____ Home Phone (_____) _____

Area Code Area Code

Alternate Recipient Information

Please complete the information below if this claim is for an alternate recipient, covered under QMCSO*

Alternate Recipient's Name: _____

First Middle Initial Last

Legal Guardian's Name:(if alternate recipient is a child) _____

First Middle Initial Last

Mailing Address: _____

Street City State Zip

Business Phone:(_____) _____ Home Phone (_____) _____

Area Code Area Code

Patient Information

Patient Name: _____

First Middle Initial Last

Relationship: Employee Spouse Child - DOB _____ Alternate Recipient (covered under QMCSO*) - DOB _____

Other Vision Benefits

Are you, your spouse, or your dependents also covered for vision benefits through any other employer group, union welfare plan or Medicare?
 Yes No If no, proceed to Employee Certification below.

If yes, attach the itemized bill along with a copy of the Explanation of Benefits (EOB – the statement describing how your benefits were paid) from the other plan or Medicare. If an EOB from the other plan or Medicare is not available, please provide the name and address of the employer and other insurance company providing vision benefits.

Name and Identification # of person covered: _____ - _____ - _____

Employer Name: _____ Insurance Administrator: _____

Address: _____ Address: _____

Employee Certification

I authorize the release of any information regarding this claim. I certify the information provided is correct and that I have not been previously reimbursed for these services, and understand that any intentional failure to complete this claim form accurately may lead to disciplinary action and/or claim denial. If this claim is for an alternate recipient, I certify that a Qualifying Court Order directs such payment.

Employee, Alternate Recipient or Legal Guardian Signature: _____ Required _____ Date: _____

*QMCSO – Qualified Medical Child Support Order

Provider Information (to be completed by provider)

ExaminerName: _____ MD/DO OD

Address: _____

City: _____ State: _____ Zip: _____

State License Number: _____

Provider Signature: _____ Phone Number: () _____

Dispenser (if different from examiner)Name: _____ MD/DO OD

Address: _____

City: _____ State: _____ Zip: _____

State License Number: _____

Provider Signature: _____ Phone Number: () _____

Services Rendered and Charges

Please check the box next to the services provided, enter the actual charged or attach itemized receipt:

| Service | Date of Service | Please Check | Amount |
|-------------------------------------|-----------------|--------------------------|--------|
| Eye Examination | (/ /) | <input type="checkbox"/> | \$ |
| Frames | (/ /) | <input type="checkbox"/> | \$ |
| Prescription Single Vision Lenses | (/ /) | <input type="checkbox"/> | \$ |
| Prescription Bifocal Lenses | (/ /) | <input type="checkbox"/> | \$ |
| Prescription Trifocal Lenses | (/ /) | <input type="checkbox"/> | \$ |
| Elective Contact Lenses | (/ /) | <input type="checkbox"/> | \$ |
| Medically Necessary Contact Lenses* | (/ /) | <input type="checkbox"/> | \$ |
| Cataract Single Vision Lenses | (/ /) | <input type="checkbox"/> | \$ |
| Cataract Bifocal Lenses | (/ /) | <input type="checkbox"/> | \$ |
| Cataract Contact Lenses | (/ /) | <input type="checkbox"/> | \$ |
| Eyeglass Tinting | (/ /) | <input type="checkbox"/> | \$ |
| | | Total | \$ |

***Provider documentation of medical necessity is required. Claim will be paid as elective (cosmetic) without such documentation.**