

# VISION CLAIM FORM

Vision Direct Reimbursement Coverage

Adventist Health System

Facility Name & Location: \_\_\_\_\_

Employee's Employer's Name: \_\_\_\_\_

Employee's Employer's Location: \_\_\_\_\_

EMPLOYEE ID: \_\_\_\_\_

EMPLOYEE Name: \_\_\_\_\_

Street Address/PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Date of Claim(s): \_\_\_\_\_ Amount of claim(s): \_\_\_\_\_

**Receipts must be attached to an itemized bill.**

Vision Provider Name: \_\_\_\_\_

Vision Provider Address: \_\_\_\_\_

Vision Provider Phone: \_\_\_\_\_

Please send to: **Eagles, Benefits By Design (Eagles)**  
**2336 SE Ocean Blvd., Suite 301**  
**Stuart, FL 34996**  
**Fax 1-772-334-7059**

If you have questions, please call 1-800-726-5603.

**PLEASE NOTE: All claims for the plan year must be filed within 60 days of the date of service.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_