

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: _____