GENERAL® VISION SERVICES

REIMBURSEMENT FORM

PLEASE FOLLOW THESE INSTRUCTIONS FOR REIMBURSEMENT:

1. Confirm information in Part 1 and Part 2 are correct. To make changes, please call I-800-VISION-1 (1-800-847-4661).
2. Sign Part 3 where indicated.
3. Return this form to General Vision Services, Attn: OON-Dept, 520 Eighth Avenue, Suite 900, New York, NY 10018 or email to oon@gvsbenefits.com with an **itemized receipt** for optical services. General Vision Services will issue reimbursement checks to the MEMBER.

PART 1: MEMBER INFORMATION

Account #: _____

Account Name: _____

Member's Name: _____ Last 4 digits of SSN:_____

Street Address: _____

City & State: _____ Zip Code: _____

Telephone: _____ Email: _____

PART 2: PATIENT INFORMATION

Patient's Name: _____

Patient's DOB: _____

Relationship to Member: ☐Member ☐Spouse ☐Domestic Partner ☐Child

PART 3: AUTHORIZED SIGNATURES *(18 years old and older)*

Patient's Signature: _____

Member's Signature: _____

FOR INTERNAL GVS USE:

Record Card # OUT: _____

Authorization #: _____ Date Processed: ____/____/____

Exam: _____ Frame: _____ Lenses: _____

Total: _____

(COMPLETE AND RETURN TO GVS WITH RECEIPT)