



MEMBER REIMBURSEMENT REQUEST

This form is used only for submitting member Out-Of-Network Reimbursement Requests, For Eyes Mail Order Contact Lenses and member In-Store Special Reimbursement Requests. In-Network member claims are submitted by the eye care provider.

In order to properly review and process your vision claim for reimbursement, please complete the following information (incomplete forms cannot be processed).

Group name _____

Employee's name _____

Employee's social security number _____

OR

Employee's ID number _____

Name of individual receiving service _____

Date of birth of individual receiving service _____

Mailing address for reimbursement

Please check all that apply (what services were provided):

- Eye Examination
- Eyeglasses (Eyeglass Lenses and/or Eyeglass Frames)
- Contact Lenses (Examination / Fitting)
- Contact Lenses (Mail Order: ForEyes or 1-800-CONTACTS)
- Purchase of In-Store Special or Promotion

Please **submit** this completed form (**via US MAIL ONLY AND WITHIN TWELVE (12) MONTHS FROM THE DATE OF SERVICE**), along with the **ORIGINAL PAID** receipt(s), to:

**Advantica EyeCare
Attention: Claims Processing Department
3290 Pine Orchard Lane
Suite C
Ellicott City, MD 21042**

Please allow thirty (30) days from receipt for processing. **CLAIMS RECEIVED THAT ARE DATED BEYOND TWELVE (12) MONTHS FROM THE DATE OF SERVICE WILL NOT BE PROCESSED.**

Should you have additional questions or require further assistance, please call Advantica EyeCare's Service Center toll free at 866.425.2323 and follow the prompts for "Member."