HEALTH ECONOMICS GROUP, INC.

VISION SERVICES CLAIM FORM

Please read these instructions before completing the claim form:
1. Employee must complete **Part I.**
2. All services must be itemized in **Part II (Claim Information)** in order for your claim to be processed. You may use one claim form fro services provided on behalf of any or all of your family members.
3. The following supporting documentation is required:
   A. *Expenses covered by your medical plan* – Vision expenses covered by your health plan(s) or those of your spouse must be submitted to that/those plan(s) first. Attach a copy of the explanation of benefits (EOB) from your medical plan or a provider's itemized statement in order for claim amounts not paid by other health care plans. ts.
   B. *Other vison care expenses* – for all other eligible Vision expenses, attach an itemized receipt that clearly states the nature of the services or supplies furnished, name and address of the service provider, date of service, amount charged for each service.
4. Read the Employee Statement, sign and date the form.
5. Mail (or fax) the completed form to the address (or fax number) provided on this form. (Be sure that EOB's and/or itemized receipts are attached to the claim form).

Part I: Employee Information (Please Print)

EmployER Name:		
EmployEE Name:		**Last 4 Digits of Social Security Number:**
Address:		**New Address?** ☐ YES ☐ NO
Daytime Phone	**Evening Phone**	

Part II: Claim Information (Please Print)

Recipient Name	Date of Birth	Vision Provider	Date of Service	Type of Service Please check the appropriate box for each expense	Covered By Medical Plan(s)?	Amount Claimed
				☐ Vision Exam ☐ Frames ☐ Lenses ☐ Single ☐ Bifocal ☐ Trifocal ☐ Progressive ☐ Lenticular ☐ Contact Lenses	Y / N	
				☐ Vision Exam ☐ Frames ☐ Lenses ☐ Single ☐ Bifocal ☐ Trifocal ☐ Progressive ☐ Lenticular ☐ Contact Lenses	Y / N	
				☐ Vision Exam ☐ Frames ☐ Lenses ☐ Single ☐ Bifocal ☐ Trifocal ☐ Progressive ☐ Lenticular ☐ Contact Lenses	Y / N	
				☐ Vision Exam ☐ Frames ☐ Lenses ☐ Single ☐ Bifocal ☐ Trifocal ☐ Progressive ☐ Lenticular ☐ Contact Lenses	Y / N	
					TOTAL	**$**

Employee Statement:

I request payment from my Vision Plan for the expenses itemized on this claim form. I certify that I have not received reimbursement under this Plan or from any other source for these expenses and that I will not seek additional reimbursement for the amount(s) paid by this Plan. I further certify that I have met all requirements for eligible expenses under this Plan. I understand that expenses for which I have been reimbursed cannot be claimed on my personal income tax return.

Employee Signature: ______________________________ **Date:** ____________

Send completed claim form to:

Health Economics Group, Inc.
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Building 1000 - Suite A-1
Fairport, New York 14450
www.heginc.com

(585) 241-9500, ext. 504
(800) 666-6690, ext. 504
FAX: (585) 241-9518