GVS | 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 #: ______________________________

Member's Name: ____ ID# ______________________________________

Street Address: ____

City & State: ____ Zip Code: ______________________________________

Telephone: __________________________________

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)