Dear Florida Blue Member,

Enclosed is the Direct Member Reimbursement Form, as requested.

For proper processing, please fill out the form completely using the below checklist:

☐ Print your name as shown on your Health Plan ID Card.
☐ Print your Member ID Number as shown on your Health Plan ID Card.
☐ Print your mailing address, telephone number and email address.
☐ The date(s) of service for each service you are requesting reimbursement for.
☐ We will need the following service provider information to process your claim:

- **The first and last name, address and NPI 1 number of the doctor who completed your exam and wrote your prescription. (aka "Referring Provider")**
- **The name, address and NPI 2 number(s) of the location(s) where you got service(s)**

☐ Please sign and date form
☐ A **copy** of the front and back of a canceled check **OR** a **copy** of bank or credit card statement showing payment
☐ A **copy** of an invoice/statement from the provider showing the following:

- Provider's Name, Address & Telephone
- Date of Service
- Services Rendered
- Balance showing paid with payment method – cash, check or credit card

Your bill must be paid in full before your reimbursement can be processed. Only services paid by personal funds at an Out-of-Network provider are eligible for reimbursement. Payments made using a Florida Blue "Blue Dollars" Card are not eligible for reimbursement.

Delivery of this form:

Email: MemberReimbursement@premiereyecare.net
Fax: 1-855-865-9727
Mail: Attn: Member Reimbursement, c/o Premier Eye Care,
P.O. Box 21503, Eagan, MN 55121

Once all requested information has been received and meets your plan's reimbursement requirements, your request will be processed within 60 days.

Please feel free to contact Premier Eye Care at the above if you have any additional questions.

Thank you,

MEMBER REIMBURSEMENT
PREMIER EYE CARE

Florida Blue
Your Health Solutions Partner

MEDICARE

Direct Member Reimbursement Form

Instructions:

1. Use this form only if you go to an out-of-network provider for vision care **and** are required to pay up-front and out-of-pocket, **and** are requesting funds be reimbursed to you.
2. Please print using a blue or black pen.
3. Claim form MUST be signed, dated, and submitted with itemized receipt(s). Incomplete forms cannot be processed.
4. **Do NOT mail the original receipt(s)**. Attach copies of your receipt(s) as proof of payment.
5. Keep a copy of this completed form for your records.
6. Member should complete 1 Form per Provider

SECTION 1: MEMBER INFORMATION					
Name:				Date of Birth:	
Address:					
Phone:		Email:		Member ID:	
Referring Provider Name:		Referring Provider NPI:		Full Practice Address:	

SECTION 2: EXPENSE INFORMATION			
Service Type:	Start Date of Service:	End Date of Service:	Reimbursement Amount:
	MM/DD/YYYY	MM/DD/YYYY	$Dollars.Cents
Vision	_____/_____/_____	_____/_____/_____	$_____.____
Provider Name:			
Vision	_____/_____/_____	_____/_____/_____	$_____.____
Provider Name:			
Vision	_____/_____/_____	_____/_____/_____	$_____.____
Provider Name:			

SECTION 3: CERTIFICATION

I certify the expenses listed above have been incurred by me. The claimed expenses have not been reimbursed, nor will I seek reimbursement from any other source. Bills, statements, receipts, or other proofs of expenses are attached. I have read and understand the instructions on the above page(s).

Signature:		Date:	_____/_____/_____

FOR VISION REIMBURSEMENT

Customer Service:	**Fax:**	Mail:
1-866-434-0015 (TTY:711)	1-855-865-9727	Premier Eye Care
Monday-Friday	**Email:**	P.O. Box 21503
8 a.m. to 8 p.m.	MemberReimbursement@premiereyecare.net	Eagan, MN 55121

Once all requested information has been received and meets your plan's reimbursement requirements, payment will be processed and mailed to you within 60 days.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. Premier Eye is an independent eye care provider contracted by Florida Blue Medicare. Florida Blue and Florida Blue Medicare are Independent Licensees of the Blue Cross and Blue Shield Association. Florida Blue is a trade name of Blue Cross and Blue Shield of Florida Inc.