Vision Member Reimbursement Request Form

Please use this form for all out-of-network claims. This includes services and materials purchased through out-of-network providers and all online purchases.

In order to properly review and process your reimbursement request, please complete the following information (incomplete forms cannot be processed). In-network member claims are submitted by the eye care provider.

Group Name/ID: _____

Subscriber Name: _____

Subscriber ID Number: _____

Subscriber Address*: _____

_____

Patient Name: _____

Patient Date of Birth: _____

**Member reimbursements will be mailed to the address on file. If your mailing address has changed, please contact your benefit administrator to update.*

Indicate the service(s) received:

☐ Eye Examination

☐ Eyeglasses (Lenses and/or Frames)

☐ Contact Lenses

☐ Contact Lens (Examination/Fitting Fee)

Please allow thirty (30) days from receipt for processing. Claims that are received dated beyond twelve (12) months from the date of service will not be processed. Complete this form and return to us along with a copy of your itemized receipt.

Mail: Advantica
PO Box 8510
St. Louis, MO 63126-0510
Fax: (314) 849-4830 or (800) 501-8432
Email: customerservice@advanticabenefits.com

Should you have any additional questions or require further assistance, please contact Advantica Customer Service at (866) 425-2323.