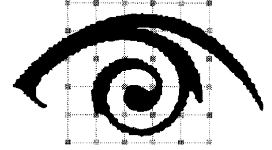
GE Benefits Participant Vision Care Benefits Claim Form

Use this claim form when:
- Using Out of Network providers
- Covered through other vision benefits

Mail completed form to:
GE Vision Care Benefits
P.O. Box 1440, Latham, NY 12110



Employee Information (to be completed by employee) PLEASE PRINT CLEARLY

Please read instructions on reverse side before completing Claim Form

GE Benefits Participant Member ID # ______________________________

GE Benefits Participant Name: ______________________________
First Middle Initial Last

Mailing Address: ______________________________
Street City State Zip

Check here if spouse or dependent is also employed by GE or a GE affiliate: ☐ Spouse ☐ Dependent

If we need additional information and you would like us to call you rather than write, please provide your daytime telephone number:

Business Phone:(____)__________________ Home Phone:(____)__________________
Area Code Area Code

Patient Information (if other than employee)

Patient Name: ______________________________ Date of Birth:____/____/_____

Relationship: ☐ Spouse ☐ Surviving Spouse ☐ Child ☐ Other: ______________________________
Please specify

Sex: ☐ Male ☐ Female

Status: ☐ Married ☐ Employed full time

☐ Full-Time student: ______________________________
School or College Expected Graduation Date

☐ Disabled: ______________________________
Reason Date Disability Began Expected Length of Time

Other Vision Benefits

Are you, your spouse or dependents also covered for vision benefits through any other group, union welfare plan or Medicare? Yes ☐ No ☐
If no, proceed to Employee Certification area below.

If yes, attach the itemized bill along with a copy of the Explanation of Benefits (EOB – the statement describing how your benefits were paid) from the other plan or Medicare. If an EOB from the other plan or Medicare is not available, please provide the name and address of the employer and other insurance company providing vision benefits:

Name and ID Number (Identification #) of person covered:

______________________________ ______________________________

Employer Name: ______________________________ Insurance Administrator: ______________________________

Address: ______________________________ Address: ______________________________

Employee Certification

I authorize the release of any information regarding this claim. I certify that the information provided by me is correct and that I have not been previously reimbursed for these services. I understand that any intentional failure to complete this claim form accurately may lead to disciplinary action.

Employee's Signature (REQUIRED): ______________________________ Date: ______________________________

Employee Instructions

1. This form is used to allow eligible participants to receive direct reimbursement. Prior to receiving services you may call 1-800-433-9375 to verify eligibility, determine benefits or obtain additional information.
2. Reimbursement for eye examination, frames and/or lenses (and contact lenses) can be claimed on this form.
3. Be sure all sections have been completed and that you and the provider(s) have signed the form.
4. Important: The examiner and dispenser information must be completed and service dates must be entered.
5. To have your vision benefit reimbursement paid directly to the provider(s), please sign and check appropriate box below.
6. Mail completed form to: GE Vision Benefits, P.O. Box 1440, Latham, NY 12110.
7. Itemize all services and charges in their respective areas below.
8. **FOR PATIENTS RESIDING IN TN ONLY:** Tennessee state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Provider Information (to be completed by provider)

Examiner:

Name: ______________________ Assignment#: ______________________

Address: ______________________

City: ______________ State: ______________ Zip: ______________

Federal Tax I.D. Number: ______________________ Please check appropriate box: ☐ Member ID ☐ EIN

If EIN, check one: ☐ Individual ☐ Partnership ☐ Corporation ☐ Other

Provider Signature: ______________________ Phone Number: (____) ______________

Dispenser:

Name: ______________________ Assignment#: ______________________

Address: ______________________

City: ______________ State: ______________ Zip: ______________

Federal Tax I.D. Number: ______________________ Please check appropriate box: ☐ Member ID ☐ EIN

If EIN, check one: ☐ Individual ☐ Partnership ☐ Corporation ☐ Other

Provider Signature: ______________________ Phone Number: (____) ______________

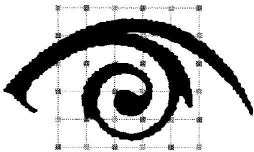
I authorize payment of my vision benefit reimbursement to the: ☐ Examiner ☐ Dispenser ☐ Employee

Employee's Signature (Required for payment to be made to the provider(s):______________________

Date: ______________

Services Rendered and Charges

Please place check mark next to the services provided, and enter the actual amount.



Service	Date	Please Check	Amount
1. Eye Examination		☐	$
2. Frames		☐	$
3. Single Vision Lenses (not plano)		☐	$
4. Bifocal Lenses		☐	$
5. Trifocal Lenses		☐	$
6. Contact Lenses Circle One: Daily Wear/Disposable Circle one: Single Vision/Bifocal		☐	$
7. Cataract Single Vision Lenses		☐	$
8. Cataract Bifocal Lenses		☐	$
9. Cataract Contact Lenses		☐	$
Total			$