CONTROL #:_____

GVS | GENERAL VISION SERVICES

EXECUTIVE OFFICE:
520 8th Avenue, 9th Floor
New York, NY 10018
Phone: (212) 729-5300 Fax: (646) 519-2678

REIMBURSEMENT FORM

Account #: _____ Account Name: _____

ISSUED TO: _____ DATE ISSUED: _____
[Expires In 30 Days]

Street Address: _____

City & State: _____ Zip Code: _____

PART 1: PATIENT INFORMATION

Member's Name: _____ Social Security # _____

Street Address: _____

City & State: _____ Zip Code: _____

Telephone: _____ (Home) _____ (Work) _____

Patient's Name: _____ ☐ Male ☐ Female

Social Security # _____ Patient's DOB: _____

Relationship to Patient: ☐ Member ☐ Spouse ☐ Child

PART 2: AUTHORIZED SIGNATURES *(18 years old and older)*

Patient's Signature: _____

Member's Signature: _____

FOR INTERNAL GVS USE:

Date Request Received: _____ Authorization Number: _____

Date Check Issued: _____ Check Number: _____

Date Check Mailed: _____

PLEASE FOLLOW THESE INSTRUCTIONS FOR REIMBURSEMENT:

1. Confirm information in Part I is correct. To make changes, please call I-800-VISION-1 (1-800-847-4661).
2. Sign Part II where indicated.
3. Return this form to General Vision Services, Att: OON-Dept, 520 Eighth Avenue, Suite 900, New York, NY 10018 Reimbursement with an **itemized receipt** for optical services. General Vision Services will issue reimbursement checks to the MEMBERS NAME unless otherwise requested.

(COMPLETE AND RETURN TO GVS WITH RECEIPT)