Harvard Pilgrim Health Care | Cape Cod Healthcare

a Point32Health company

$100 Vision Reimbursement

Cape Cod Healthcare plans include a $100 vision hardware reimbursement benefit (glasses and contacts, including measurement, fitting and adjustment) per plan year, per plan member. Please use a separate claim form for each covered member of the family and include proof of payment in your submission. Forms must be submitted by March 31 of the following year.

Member Information

Patient Name (Last, First, Middle Initial): _____

Date of Birth: _____ / _____ / _____ Sex: ❑ M ❑ F Harvard Pilgrim ID# | | | | | | | | | | | | |

Patient's Relationship to Plan Subscriber: ___ Self ___ Covered Plan Dependent

Address: _____ Telephone: _____

Vision Provider Information

Physician or Vision Services Retail Store Name: _____

Telephone: _____ Address: _____

Amount Paid: _____ Date of Purchase: _____ / _____ / _____

Item Purchased: ❑ Eyeglasses ❑ Contact Lenses

Payment Information

Please indicate which one of the following forms of proof of payment you are including with this form:

❑ The front and back of the cancelled check written to the physician or vision services retail store or the bank-encoded front of the check written to the physician or vision services retail store

❑ A credit card statement or receipt of payment

Signature Required

I attest that the above information is true and accurate, and the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be canceled and I may be subject to criminal and/or civil penalties for false health care claims. I also understand that Harvard Pilgrim Health Care may request any additional information it deems necessary to verify that services were received and payment was made. I understand that this reimbursement may be considered taxable income.

Note: If patient is younger than 18 years old, the subscriber or a parent/guardian must sign this form.

Signature: _____ **Date:** _____

Please submit this form and all documentation to:

Harvard Pilgrim Health Care
1 Wellness Way
Floor C1
Canton, MA 02021-1166

Please do not staple any materials to this form