Claim Submissions Made Easy

When visiting a provider where you are responsible for payment of services and/or materials at the time of service, use this claim form to request reimbursement for authorized services according to your plan document. Send your completed form and itemized receipts that indicate the services provided and the amount charged for each service. Services must be paid in full to receive reimbursement. Paper claims can be submitted to: **Interactive Medical Systems, PO Box 1349, Wake Forest, NC 27588.**

Vision Coverage Claim Form

This form is designed for you to complete and submit online or to download, complete and mail. Enclose (upload) itemized receipts from your vision care provider confirming charges.

1. Member Name	2. Member ID # (from ID card)	3. Member Group # (from ID card)
4. Member Address		5. Phone Number
6. Patient Name		7. Patient Date of Birth

8. Is Patient Covered for Vision Care by Another Plan ○ Yes If yes, complete boxes 9 through 11 ○ No	9. Name of Other Carrier/Plan
10. Cardholder Name	11. Relationship to Member ____ Self ____ Spouse ____ Child ____Other

12. CHECK ITEMS BELOW THAT APPLY TO THE SERVICES RENDERED BY YOUR VISION PROVIDER AND ATTACH DOCUMENTATION

DATE OF SERVICE_____ DIAGNOSIS_____ ___EXAM $_____ ___CONTACT LENS FITTING/EXAM $_____ ___CONTACT LENSES $_____ ___EYEGLASS LENSES $_____ ___FRAME $_____ ___OTHER $_____	PROVIDER NAME_____ PROVIDER ADDRESS _____ _____ _____ PROVIDER PHONE NUMBER _____

13. By signing below, you are authorizing the release of any information to Interactive Medical Systems (IMS) and certifying the information provided in support of this claim is complete and correct. If the patient is a minor, a parent must sign the statement. Other authorized representatives include caretaker, guardian or other individual as appropriate under state law and the circumstances of the case. By signing the statement, the patient (or parent or other authorized representative), consents to the use and disclosure of information relating to the services provided by the health care professional for the purpose of treatment, payment or health care operation, including submission of a claim for benefits to a provider or administrator of dental benefits.

SIGNATURE OF MEMBER_____ DATE SIGNED_____

What Happens Next?

Each time IMS processes a claim submitted by you or your healthcare provider, we explain how we processed it in the form of an Explanation of Benefits (EOB). If you have not received your EOB within 30 days from submission of your Vision Claim Form, please call IMS at 800-426-8739 for confirmation that your claim was received. Please call IMS with any questions at 800-426-8739 Option 2 for Member.