MAIL/FAX TO:
Attn: Member Services
939 Elkridge Landing Road
Suite 200
Linthicum MD 21090
-or-
24-Hour Fax Line: **410-752-9184**

block vision
A Superior Vision Company

evergreen HEALTH

Exception Request for Reimbursement

INSTRUCTION: Please fill out all requested fields. Incomplete forms may be returned for additional information.
Note: Completing this form does not guarantee eligibility for reimbursement.

SECTION I: PATIENT INFORMATION

Patient Name:	**Date of Request:**
Member or Subscriber ID:	**Provider Name:**
DOB:	**Provider Address:**
Patient's Health Plan:	**Provider City, State, Zip:**
Patient's Phone#:	**Provider Phone #**
Patient's Address:	**Patient's City, State, Zip:**
Reimbursement amount requested: $	

SECTION II: BE SURE TO COMPLETE THIS SECTION AND INCLUDE RECEIPT

Remember to attach copy of receipt and any relevant supporting documents. Describe situation and reason you feel you should not have been charged for the materials or services and are entitled to reimbursement: (Please be aware that your insurance may not provide coverage for materials or services you received from a non-participating provider.)

SECTION IV: IF REQUEST IS FOR MATERIALS

Are materials related to cataract surgery? No ____ Yes ____ (indicate Date of Last Surgery) _____

Please break down charges:

Exam (glasses): _____ Exam (contact lenses): _____

Frame: _____ Contact Lenses: _____

Lenses: _____ Other (describe): _____

Lens upgrades: _____