CAMBRIDGE PUBLIC EMPLOYEES DENTAL & VISION FUND

VISION BENEFITS CLAIM FORM

Before obtaining services, please verify eligibility by calling the Fund Office at 617-354-1110 or email visionclaim@cdvfund.org.

Please complete the following steps before submitting a claim. Any ineligible, **incomplete or missing information** may result in a claim being delayed or denied. Claims must be submitted **within one (1) year from the date of service in its entirety**. There is **NO reimbursement for services from International Optical or for exams, contact fittings, or non-prescription vision materials; only frames, lenses, and contacts.**

1. **Must include an itemized paid bill** that indicates the date of service, patients name, provider(s) information, services received, and amount charged for each item – lenses, frames, or contacts. Must be paid with **no outstanding balance due**.
2. **Verification of payment** – receipts, charge slips, copy of cancelled check, or credit card statement. The words **"Paid In Full"** written, stamped, etc. on the itemized bill are not acceptable as verification of payment.
3. A separate claim form must be completed for the member and/or dependent(s) requesting reimbursement.
4. **One (1) claim submission** will be allowed for each 24-mth or each 12-mth eligibility period for dependent children under age 14.
5. **Must utilize the full $450 maximum vision allowance within a 30-day period from the first date of service** for any combination of lenses, frames, and contacts. In other words, if you purchase multiple pairs of lenses, frames, and/or contacts you must purchase all items within a 30-day period of the first date of purchase. Any portion of the vision allowance that is not utilized **may not be carried over** for additional claims.
6. Sign and date claim form, and submit by mail or email.

   Mailing Address: Cambridge Public Employees Dental & Vision Fund
   125 CambridgePark Drive, Suite 104
   Cambridge, MA 02140

   Email Address: **visionclaim@cdvfund.org**
7. To submit claims by email you **must scan and attach** claim form, itemized bills and receipts. **Format must be pdf (click for link).**

MEMBER INFORMATION (SUBSCRIBER)

PLEASE PRINT CLEARLY

*REQUIRED INFORMATION

FIRST NAME*	LAST NAME*

LAST 4 DIGITS OF SSN*	DATE OF BIRTH*	PRIMARY PHONE*	SECONDARY PHONE
XXX – XX –			

STREET ADDRESS*	IS THIS A NEW ADDRESS: YES ☐ NO ☐

CITY*	STATE*	ZIP CODE*	STATUS
			EMPLOYEE ☐ RETIREE ☐

DEPARTMENT: ACTIVE EMPLOYEE*	EMAIL ADDRESS*

COMPLETE INFORMATION IF CLAIM IS FOR DEPENDENT (SPOUSE/CHILD)

PLEASE PRINT CLEARLY

FIRST NAME	LAST NAME

RELATIONSHIP TO MEMBER	DATE OF BIRTH	
SPOUSE ☐ CHILD ☐		**DISABLED DEPENDENT VERIFICATION** REQUIRED FOR DEPENDENT CHILDREN AGE 26 OR OLDER → CHECK IF DISABLED DEPENDENT ☐

The Board of Trustees may suspend or, in some case, terminate the vision benefits of any person who files a claim containing any misrepresentation or any false, incomplete, or misleading information.

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any provider named to disclose all known facts concerning this claim. A copy or photocopy of this authorization shall be as valid as the original.

MEMBER SIGNATURE (REQUIRED)*	TODAY DATE

OFFICE USE ONLY

RCD	FUND#	UC#	DEPT	LDS