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 info@cdvfund.org.

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

1. **Vision claims with a date of service on or after September 1, 2022 are entitled up to $450 reimbursement**, **vision claims with a date of service before September 1, 2022 are entitled up to $300 reimbursement** during each eligibility period.
2. **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**.
3. Attach **verification of payment** – receipts, charge slips, copy of cancelled check, or credit card/bank statement. The words **"Paid In Full"** written, stamped, etc. on the itemized bill are not acceptable as verification of payment.
4. A separate claim form must be completed for the member and/or dependent(s) requesting reimbursement.
5. Only **one (1) claim submission** will be allowed for each 24-month eligibility period or for each 12-month period for dependent children under age 14. **You must utilize the vision allowance within 30 days of the first date of service**; any portion of the maximum allowance that is not utilized may not be carried over for any 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*

FIRST NAME	LAST NAME

LAST 4 DIGITS OF SSN	DATE OF BIRTH	HOME PHONE	OTHER PHONE
XXX – XX –			

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

CITY	STATE	ZIP CODE	STATUS
			EMPLOYEE ☐ RETIREE ☐

DEPARTMENT: ACTIVE EMPLOYEE	EMAIL, IF HAVE ONE

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	TODAY DATE

OFFICE USE ONLY

RCD	FUND#	UC#	DEPT	LDS