

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 the claim form to the Fund Office. Any ineligible, incomplete or missing information may result in a claim being delayed or 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**.

1. Fund Office will only accept **itemized paid bills** that indicate 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. 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.
3. A separate claim form must be completed for the member and/or dependent(s) requesting reimbursement.
4. 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.
5. The vision benefit **must be used within 30 days of the first date of service** for any combination of lenses, frames, and/or contacts. Any portion of the allowable \$300 benefit 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 XXX – XX –	DATE OF BIRTH	HOME PHONE		OTHER PHONE	
STREET ADDRESS					IS THIS A NEW ADDRESS: YES <input type="checkbox"/> NO <input type="checkbox"/>
CITY		STATE	ZIP CODE	STATUS EMPLOYEE <input type="checkbox"/> RETIREE <input type="checkbox"/>	
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 SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/>	DATE OF BIRTH	FULL-TIME STUDENT OR DISABLED DEPENDENT VERIFICATION REQUIRED FOR DEPENDENT CHILDREN 19 TO 25 YEARS OF AGE		CHECK IF FULL TIME STUDENT/ DISABLED DEPENDENT <input type="checkbox"/>	

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
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OFFICE USE ONLY

RCD	FUND#	UC#	DEPT	LDS
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