

CAMBRIDGE PUBLIC EMPLOYEES DENTAL & VISION FUND

VISION 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 prior to submitting a vision claim to the Fund. 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**. A separate claim form must be completed for each individual (member and/or dependents) requesting reimbursement.

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. 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. **Vision Prescription** that indicates date of service, patients name, and provider(s) information.
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 14 years of age.
5. If purchasing more than one (1) combination of lenses, frames, and/or contacts it **must be purchased within 30 days of the first purchase**. Any portion of the allowable \$450 benefit that is not utilized within the 30 days may not be carried over.
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 **must be scanned – “PDF FORMAT.”** Photo images, pictures, and non-scanned claims **will not be accepted**.

SECTION 1: MEMBER INFORMATION (EMPLOYEE/RETIREE)

PLEASE PRINT CLEARLY

LAST NAME		FIRST NAME		M.I.
LAST 4 DIGITS OF SSN		DATE OF BIRTH (MM/DD/YYYY)	PRIMARY PHONE	SECONDARY PHONE
XXX – XX –				
HOME ADDRESS (STREET, APT/SUITE)				NEW ADDRESS:
				☐ YES ☐ NO
CITY			STATE	ZIP CODE
STATUS		EMAIL ADDRESS		
☐ ACTIVE ☐ RETIREE				

SECTION 2: DEPENDENT INFORMATION IF CLAIM IS FOR DEPENDENT SPOUSE OR CHILD

LAST NAME		FIRST NAME		M.I.
DATE OF BIRTH (MM/DD/YYYY)		RELATIONSHIP TO EMPLOYEE/RETIREE	Dependent children between the ages of 19-26 are eligible under the subscriber coverage with proof of eligibility, either an age 19-26 affidavit (must be claimed on taxes), or a full-time student status verification from their school. Permanently disabled dependents must have a disabled dependent application on file to be eligible.	
		☐ SPOUSE ☐ CHILD		

SECTION 3: EMPLOYEE / SUBSCRIBER SIGNATURE & COVERAGE AUTHORIZATION

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.

SUBSCRIBER (EMPLOYEE/RETIREE) SIGNATURE	DATE (MM/DD/YYYY)

SECTION 4: OFFICE USE ONLY

RECEIVED	FUND#	UC#	DEPT	LAST DATE OF SERVICE