# MEMBER REIMBURSEMENT REQUEST FORM

In order to properly review and process your vision claim for reimbursement, please complete the following information (incomplete forms cannot be processed). Please note that this form is used for Out-of-Network reimbursements, Store Specials, and Mail Order Contact Lenses ONLY. In-Network member claims are submitted by the eye care provider. Member Reimbursements will be mailed to the address on file. If your mailing address has changed, please contact your benefit administrator to update.

**Group Name/ID:** _____

**Name of Subscriber:** _____

**Subscriber ID Number:** _____

**Subscriber Address** _____

_____

**Name of Individual Receiving Services:** _____

**Date of Birth of Individual Receiving Services:** _____

Please indicate which services were received (check your specific plan type to determine coverage of benefits):

_____ Eye Examination

_____ Eyeglasses (Lenses and/or Frames)

_____ Contact Lenses

_____ Contact Lens (Examination / Fitting Fee)

Please submit this completed form along with a copy of your itemized receipt to:

**Advantica**
**Attn: Claims Department**
**3290 Pine Orchard Lane**
**Suite 105**
**Ellicott City, MD 21042**

Please allow thirty (30) days from receipt for processing. Claims that are received dated beyond twelve (12) months from the date of service will not be processed.

Should you have additional questions or require further assistance, please call Advantica's Customer Service toll-free at (866)-425-2323.