VISION SERVICES CLAIM FORM

PLEASE PRINT OR TYPE

Member Name:________________________________
Last First

Member Date of Birth:_____/_____/_____
MM DD YY

Mailing Address: ____
Street Apt#

____
City State Country Zip Code

Client Name: Concordia Plan Services

Daytime Phone: ______________________

Benefits Requested For: Last Name First Relationship to member	Sex	Date of Birth
☐ 1.		
☐ 2.		
☐ 3.		
☐ 4.		

Please check off all that apply

- ☐ Exam
- ☐ Single Vision Lenses
- ☐ Bifocal Lenses
- ☐ Trifocal Lenses
- ☐ Lenticular Lenses
- ☐ Frames
- ☐ Elective Contact Lenses
- ☐ Medically Necessary Contact Lenses

PLEASE MAIL TO:
VISION SERVICE PLAN
Claims Department
P.O. BOX 997105
Sacramento, Ca 95899-7100
UNITED STATES

In The United States Call - 1-800-877-7195
Outside The United States Call Collect (916) 635-7373

Please be sure to write the member name, and the patient’s name on each receipt and attach them to this form.