JFP Benefit Management, Inc.

Vision Claim Form

Complete & Return to:
JFP Benefit Management, Inc.
P.O. Box 189, Jackson, MI 49204
(517) 784-0535 Phone – (800) 589-7660
(517) 784-0821 Fax
cservice@jfpbenefitmanagement.com

Use this form to submit payment and/or reimbursement requests for vision care services. Please complete a separate form for each family member.

1. Enter all requested information in the Employee Information Section.
2. If the Employee is not the patient, enter all requested information in the Patient Information Section.
3. Enter all requested information in the Provider Information Section.
4. Attached itemized receipt/statement from provider.
5. Sign and date the claim form.
6. Mail or fax completed claim form to JFP Benefit Management, Inc., PO Box 189, Jackson, MI 49204 – Fax (517) 784-0821

Employee Information

Name, (Last, First, Middle Initial)	**Birth Date**
Street Address, City, State, Zip	**Telephone**

Are you covered for vision benefits under any other plan? If yes, please enter other plan information below and attach copy of EOB:

Patient Information **Patient is the Employee** ☐ **Yes** ☐ **No**

Name, (Last, First, Middle Initial)	**Relationship**	**Birth Date**
Street Address, City, State, Zip		

Is patient covered for vision benefits under any other plan? If yes, please enter other plan information below and attach copy of EOB:

Provider Information

Provider Name, Address, Zip Code

Tax ID #	**Telephone Number**	**Date of Service**

Request for Payment or Reimbursement (Remember to include itemized receipt/statement from provider)

Exam	**Frames**	**Lenses**	**Contacts**	**Other**	**Total Charge**
$ _____	**$ _____**	**$ _____**	**$ _____**	**$ _____**	**$ _____**

Please make payment to:

☐ **Please pay provider** ☐ **Please pay Employee**

Important

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: *(1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.*

I authorize the release of any medical or other information necessary to process this claim. By signing below, I acknowledge that I have read the applicable Fraud Warning Statement above.

Employee's Signature	**Date**