New York State Vision Plan

For Employees of the State of New York

Represented by the Police Benevolent Association PBA-Supervisors (PBA-S), PBA-Troopers (PBA-T)

and for their enrolled dependents
and for COBRA enrollees and their families with PBA-S, PBA-T vision care benefits

April 2025

State of New York
Department of Civil Service
Employee Benefits Division
www.cs.ny.gov

NEW YORK STATE

NYSHIP
New York State
Health Insurance Program

DavisVision™

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Introduction

The NYS Vision Plan provides you, your spouse or domestic partner and your covered dependents with eye care services and materials. The plan is administered by Davis Vision, Inc., a national leader in the vision care industry.

With Davis Vision, quality care is easy to find. Enrollees have access to a nationwide network, including more than 2,304 providers across New York State. The network includes independent practice eye doctors as well as major optical retailers, including:

Davis Vision verifies enrollee eligibility with the network provider, processes claims and reimburses the provider for in-network services or the enrollee for out-of-network services. Davis Vision also operates a Customer Relationship Center (Contact Center) to support the plan and manage the national network of vision providers.

The Importance of Vision Care

Vision care is an important benefit, as regular eye exams help ensure visual and overall health. Comprehensive eye exams not only detect the need for vision correction, but can also reveal medical conditions such as diabetes or high blood pressure.

How to Enroll

If you are newly eligible for the NYS Vision Plan and you decide to participate, you must sign up for coverage. You will not be covered automatically. To enroll for coverage, file Form PS-404 with your agency Health Benefits Administrator. You are eligible for benefits after you have completed 28 days of eligible employment. If you were previously assigned to another bargaining unit as a New York State employee, coverage as a Police Benevolent Association represented employee will begin on the 1st day of the second payroll period following the one in which your bargaining unit changed.

Types of Coverage

You can choose one of two types of coverage:

- **Individual coverage** provides benefits for you only. It does not cover your dependents even if they are eligible for coverage.
- **Family coverage** provides benefits for you and your eligible enrolled dependents. To enroll yourself and your dependents in Family coverage, you must provide each person's date of birth, Social Security number (if one is assigned) and other information to the Vision Plan through your agency Health Benefits Administrator.

If you did not enroll when you were first eligible, contact your agency Health Benefits Administrator to request an enrollment form (PS-404).

If you qualify for and want to make a change from Individual to Family coverage, contact your agency Health Benefits Administrator.

Using Your Benefits

The vision benefits described in this booklet are available to you, your spouse or domestic partner and covered dependents age 19 or over once every 24 months. Covered dependents under the age of 19 can receive benefits once every 12 months. Before receiving services, you can confirm eligibility by visiting the New York State Department of Civil Service website at https://www.cs.ny.gov. On the Civil Service home page, select Benefit Programs, then select NYSHIP Online and if prompted, choose your group and plan. Then select Other Benefits and then Vision Benefits and follow the links to the Davis Vision Website, or call Davis Vision's customer call center at 888-588-4823.

The NYS Vision Plan is easy to use; simply follow the steps below to receive services.

Using a Participating Provider

To get the most out of your vision plan, consider receiving services at a provider who participates on the Davis Vision Network. These "in-network" or "participating" doctors have agreed to meet certain quality standards, and Davis Vision monitors their ongoing performance to help ensure quality member care.

In-network benefits are easy to use, as the provider will file the claim on your behalf. You will only need to do the following:

1. **Locate a Provider:** You can locate providers by visiting the New York State Department of Civil Service website at https://www.cs.ny.gov. On the Civil Service home page, select Benefit Programs, then select NYSHIP Online and if prompted, choose your group and plan, then select Other Benefits and then Vision Benefits and follow the links to the Davis Vision Website. Once on the Davis Vision website select "Find a Provider" or you can call Davis Vision's Customer Contact Center at 888-588-4823.

2. **Schedule an Appointment:** Schedule an appointment with your selected provider and identify yourself as a member of the New York State Vision Plan.

3. **Obtain Services:** Present your Davis Vision ID card at the time of service and the provider will take care of the rest. Your provider will verify eligibility, explain your benefit coverage and answer any questions you may have.

Using a Non-Participating Provider

Should you decide to obtain vision services from a doctor who does not participate in the Davis Vision Network, you will be eligible for "out-of-network" or "non-participating" reimbursements as defined in the Benefit Overview on page 3 of this booklet. Be sure to confirm eligibility before receiving services. The out-of-network process is as follows:

1. ***Obtain an Out-of-Network Claim Form:*** Print an out-of-network claim form by visiting the New York State Department of Civil Service website at https://www.cs.ny.gov. On the Civil Service home page, select Benefit Programs, then select NYSHIP Online and if prompted, choose your group and plan. Then select Other Benefits and then Vision Benefits and follow the links to the Davis Vision Website, or call the Davis Vision Customer Contact Center at 888-588-4823.

2. ***Pay for Services:*** At the time of your appointment, pay for all services and materials in full and obtain an itemized receipt.

3. ***Mail Claim Form and Receipts:*** Send the completed claim form and receipts to Davis Vision at the following address:

   ATTN: Vision Care Processing Unit
   Post Office Box 1525
   Latham, New York 12110
   Fax: 518-220-6012

4. ***Reimbursement:*** Davis Vision will process the claim and reimburse you directly up to the allowed amounts.

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Benefit Summary – Standard Plan

Benefits under the plan are available to employees and covered dependents age 19 and over once in any 24-month period. Benefits are available to covered dependents up to, but not including age 19, once in any 12-month period. The benefit does not cover both lenses and contacts.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary:	**$0**	**$20**
Frames:		
Non-Collection Frame Allowance (Retail):	80% of balance over $130 Retail Allowance	
Davis Vision Collection:		$22
Fashion level	$0	
Designer level	$0	
Premier level	$0	
Standard Plastic Lenses:		
Single Vision	$0	$22
Bifocal	$0	$30
Trifocal	$0	$40
Cataract (Lenticular and Aphakic)	$0	$35
Lens Options:		
Glass	$0	N/A
Blended Segment	$0	N/A
UV Coating	$0	N/A
Tint (Solid and Gradient)	$0	N/A
Standard Scratch-Resistance	$0	N/A
Fashion Tints	$0	N/A
Polycarbonate	$0	N/A
Progressive: Standard | Premium	$0	N/A
Ultra/Digital Progressives	$90	N/A
Intermediate lenses	$30	N/A
High Index	$0	N/A
Photosensitive – Plastic	$50	N/A
Photosensitive - Glass	$0	N/A
Standard Anti-Reflective Coating	$35	N/A
Premium Anti-Reflective Coating	$48	N/A
Ultra Anti-Reflective Coating	$60	N/A
Polaroid	$60	N/A

Contact Lenses: Prescription for contact lenses are valid for one year only. NYS State law requires that the contact lens wearer get a new eye exam before a new prescription is issued. The NYS Vision Plan covers an eye exam once every 24 months for employees and covered dependents age 19 and older. The cost of an eye exam more frequently than 24 months is the responsibility of the member.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Non-Collection Contract Lenses:		
Conventional Contact Lenses Allowance	80% of balance over $105 Retail Allowance	$184[1/]
Disposable Contact Lenses Allowance	80% of balance over $105 Retail Allowance	$184[1/]
Collection Contact Lenses (in lieu of Allowance):		
Planned Replacement (2 boxes/multi-packs)	Included	N/A
Disposable includes specialty contact lenses examples: toric, multifocal, etc. (4 boxes/multi-packs)	Included	N/A
Evaluation, Fitting & Follow-Up Care – Standard Lens Types	Included	
Evaluation, Fitting & Follow-Up Care – Specialty Lens Types	Included	N/A
Eye Exam and Contact Lenses		$200

[1/] Out-of-Network Contact Lens allowance of $184 applies to Contact Lens Fit and Follow-Up and Materials, and reimbursements must be claimed at the same time on one claim form.

Additional Plan Features

OCCUPATIONAL BENEFIT

Benefits under the Occupational Program are available to employees once in any 24-month period. The occupational vision benefit provides you with Plan coverage for an additional pair of job-related eyeglasses if determined necessary by a participating provider based on your job duties and through special testing done in conjunction with your regular vision examination. Occupational eyeglasses must differ from a patient's standard eyeglasses and meet certain criteria in order to be covered. Occupational eyeglasses are available to employees only; dependents are not eligible for this benefit. Sun sensitive and polarized lens options are available for occupational eyeglasses. **This benefit is not available to COBRA enrollees**.

Contact lenses: are not available under this Occupational Program.

In-Network Services: All services must be obtained from a participating provider. There is no out-of-network reimbursement.

MEDICAL EXCEPTION VISION BENEFIT

Under the Medical Exception Program, enrollees and covered dependents with a medical condition that may impact vision refraction, when referred by the physician caring for that medical condition may be eligible for an eye examination after twelve months.

If at least one year has elapsed since the Plan last provided benefits, you have one of the following medical conditions and you are under the care of a medical practitioner for that condition, you are eligible for an examination with dilation:

1) diabetes;

2) cataracts;

3) keratoconus;

4) cataract surgery within two years of last prescription

5) you are taking a prescription drug which could cause vision changes, or;

6) any other condition which could reasonably be expected to result in a change in refractive status.

You are eligible for new lenses or contacts under the Standard Plan if you experience a significant vision loss due to a medical condition. Significant prescription change is defined as a minimum change of .75D sphere and/or 1.00D cylinder or more since your last eye examination. You are only eligible for new frames if your current frames are broken or if you need new lenses that will not fit in your current frames. Employees may also be eligible for new lenses under the Occupational Program if they meet additional criteria under that Program.

> **Prior to receiving services**, ask your vision care provider to complete the Medical Exception Request Form. To request the form contact the Davis Vision Customer Contact Center at 1-888-588-4823. You must also provide your vision care provider with documentation from a medical practitioner that states you are receiving care for one of the qualifying medical conditions under the Medical Exception Program. Have your vision care provider fax the completed Medical Exception Request Form and documentation from your medical provider to Davis Vision's Medical Director for approval.

Refer to the Standard Plan and Occupational Program Benefits Summary for additional information on plan allowances.

LASER VISION CORRECTION DISCOUNTS

Members and Dependents will receive significant savings including 40% - 50% off the national average price of traditional LASIK.

Davis Vision's laser providers are credentialed according to NCQA standards and represent ophthalmologists and surgeons who use the latest, most advanced instrumentation. The discount program is applicable to LASIK and PRK.

To locate a participating laser vision correction provider and learn how to schedule your pre-operative evaluation, call 1-888-588-4823 or Visit New York State Department of Civil Service website at https://www.cs.ny.gov. On the Civil Service home page, select Benefit Programs, then select NYSHIP Online and if prompted, choose your group and plan. Then select Other Benefits and then Vision Benefits and follow the links to the Davis Vision website to locate a provider.

CATARACT CARE

If you or your covered dependents have cataract surgery and are enrolled in the New York State Health Insurance Program, additional benefits may be available under the Empire Plan or your HMO.

PLAN LIMITATIONS/EXCLUSIONS

The following items are standard exclusions of Davis Vision's proposed primary vision care program:

- Medical treatment of eye disease or injury
- Visual therapy
- Special lens designs or coatings other than those described in the benefit plan
- Replacement of lost/stolen eyewear
- Non-prescription (Plano) lenses
- Two pairs of eyeglasses in lieu of bifocals
- Services not performed by licensed personnel
- Prosthetic devices and services
- Materials and services not specified in the benefit design
- Services provided as a result of any Workers Compensation Law

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Eligibility Guidelines

You, the Enrollee

All PBA employees who are eligible to enroll for coverage in the New York State Health Insurance Program (NYSHIP) and for whom coverage under the NYS Vision Plan has been negotiated or administratively extended are eligible. You may enroll in the NYS Vision Plan even if you do not enroll in NYSHIP.
To be eligible for coverage, you must be expected to:

1. work at least six biweekly payroll periods; and
2. work at least half time on a regular schedule; and
3. you must be on the payroll at the time you enroll.

If you begin work, then take an unpaid leave of absence, you are not eligible until you return to the payroll and complete a total of 28 days on the payroll, including days worked before your leave began.

Dependents

Dependents are also eligible, as follows:

1. Spouses or Domestic Partners

Spouses, including those legally separated, are eligible. If you are divorced or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage.

You may also enroll a same or opposite sex domestic partner as a dependent. A domestic partnership, for eligibility under the Vision Plan, is one in which you and your partner are 18 years of age or older, and unmarried at the time of application; not related in a way that would bar marriage; living together and financially interdependent for at least six months, and involved in a lifetime relationship. To enroll a domestic partner, you must provide proof that you have lived together and been financially interdependent for at least six months and that you presently satisfy the other eligibility criteria. Your agency Health Benefits Administrator (HBA) has complete information on eligibility, enrollment procedures, proof requirements and coverage dates.

Note on tax implications: Under the Internal Revenue Service (IRS) rules for domestic partners and same-sex spouses, the fair market value of vision benefits for a domestic partner or same sex-spouse who is not the enrollee's qualified dependent for Federal income tax purposes is treated as income for tax purposes. Ask your tax consultant how enrolling your domestic partner or same-sex spouse will affect your taxes

2. Children

Children under age 26 are eligible, including natural children, legally adopted children (including children in a waiting period prior to finalization of adoption), stepchildren and children of domestic partners. Other children who reside permanently in your household and who are chiefly dependent on you (more than 50%), and for whom you have assumed legal responsibility in place of the parent, are also eligible. Qualifying support and residence must have started prior to the age of 19. You must file a PS-457 Statement of Dependence form with your HBA and be able to provide documentation

Military Service Extends Eligibility

For the purposes of eligibility, up to four years may be deducted from your Child's age for service in a branch of the U.S. Military for time served between the ages of 19 and 26. To be eligible, your dependent Child must be in enrolled in school on a full-time basis, be unmarried, and not eligible for other employer group coverage. You must be able to provide written documentation from the U.S. Military showing the dates of service and provide proof of full-time status to your HBA.

3. Disabled Dependents

Unmarried dependent children age 26 or over who are incapable of supporting themselves because of a mental or physical disability acquired before termination of their eligibility for vision care coverage are eligible. For example, if your child becomes disabled before reaching age 26, the child may qualify to continue coverage as a disabled dependent.
If you have a child who qualifies for coverage as a disabled dependent, you must provide medical documentation. If you anticipate eligibility on this basis, you must file an application for your disabled dependent, form PS-451. Contact your agency Health Benefits Administrator as soon as possible after enrollment, even if your child is under the age when eligibility would normally terminate through age disqualification.

Ending Coverage and COBRA Continuation

When Coverage Ends

Vision Care benefits cease while you are on leave without pay, unless you arrange for an extension of benefits with your agency Health Benefits Administrator. If you resign, retire, transfer to an ineligible negotiating unit or are terminated, your Vision Care coverage will end **28 days after the last day of the last payroll period worked.** You may have certain rights to continue coverage as explained below.

COBRA: Continuation of Coverage

This section explains your rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal continuation of coverage law for you, your spouse or domestic partner and your covered dependents. The law requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health care coverage called "continuation coverage" at group rates in certain instances where coverage under the program would otherwise end.

The Vision Care benefits you may continue are the same benefits you receive as an active employee. This section summarizes your rights and obligations under the continuation coverage provisions of the law. If your spouse or domestic partner is also covered under the Plan, they should take the time to read this carefully.

60 Day Deadline

In order for dependents to continue coverage under COBRA, the employee or a family member is responsible for notifying the Employee Benefits Division of the New York State Department of Civil Service in writing of a divorce or termination of domestic partnership, a legal separation or of a child's losing eligible dependent status under the NYS Vision Plan within 60 days from the date coverage ends due to one of those events. Other people acting on your behalf may provide written notice to the Employee Benefits Division of a COBRA qualifying event. **If notice is not received in writing within that 60-day period, regardless of the reason, the dependent will not be entitled to choose continuation coverage.**

When you notify the Employee Benefits Division of one of these events, the Division will advise you of your right to choose continuation of coverage. You must inform the Employee Benefits Division of your desire to continue coverage within 60 days of the date you would lose coverage because of the events described previously, or 60 days from the date you are notified of your eligibility for continuation coverage, whichever is later.

A dependent who wishes to continue coverage as a COBRA enrollee must send a written request to the Employee Benefits Division within 60 days from the date coverage would otherwise end. If you, your eligible dependent or someone acting on your behalf does not choose continuation coverage, Vision Care coverage will end.

How Long You May Keep COBRA Coverage

You, the employee, will have the opportunity to maintain continuation coverage for 36 months. Dependents who were covered at the time of your initial qualifying event, and newborns or newly adopted children added to your COBRA continuation coverage within 30 days of birth or final adoption during your period of COBRA coverage, are considered qualified beneficiaries with their own rights to continue COBRA coverage for up to 36 months in the event of a second qualifying event. Other dependents added to your COBRA coverage, such as a newly acquired spouse or child.

Enrolled spouses/domestic partners and dependent children who lose eligibility due to a COBRA qualifying event have the opportunity to elect COBRA continuation coverage for up to 36 months.

Who Is Eligible For COBRA: You

If you are an active employee enrolled in the NYS Vision Plan, you have the right to continue coverage if you lose your coverage because of a reduction in your hours of employment or the termination of employment.

Spouses or Domestic Partners

The spouse or domestic partner of an employee covered as the employee's dependent by this Plan has the right to continue coverage if coverage under this Plan is lost for any of the following reasons:
1. Your death;
2. Termination of your employment;
3. Reduction in your hours of employment with New York State;
4. Divorce or termination of domestic partnership;
5. Legal separation (spouses only) -- Your spouse does not automatically lose Vision Care coverage if you are legally separated. However, if your spouse loses coverage under this Plan, he or she may continue coverage under COBRA.

Dependent Children

A dependent child of a covered employee has the right to continue coverage if coverage under this Plan is lost for any of the following reasons:

1. The dependent ceases to be an eligible "dependent child" under this Plan;
2. The termination of your employment;
3. A reduction in your hours of employment with New York State;
4. Your divorce or termination of domestic partnership;
5. Your legal separation (NOTE: A dependent child does not automatically lose coverage because of parents' legal separation).
6. Your death.

When You or Your Dependents No Longer Qualify for COBRA

New York State law provides that your COBRA coverage may be cancelled for any of the following reasons:
1. If New York State no longer provides Vision Care coverage to State employees;
2. If the premium for your COBRA coverage is not paid on time;
3. If you become entitled to Medicare benefits during the COBRA continuation period.

Costs Under COBRA

You will have to pay the entire premium for your continuation coverage plus a two (2) percent administration fee. You will have 45 days starting with the date you choose continuation coverage to pay any premium. After this 45-day period, you will have a grace period of 30 days to pay any subsequent premiums.

Who to Contact

If you have any questions about COBRA, please contact your agency Health Benefits Administrator.

Glossary of Terms

Term	*Definition*
Conventional Contact Lenses	Traditional contact lenses worn for six months or longer.
Disposable Contact Lenses	Contact lenses that must be replaced within a certain period of time, typically every 1 or 2 days.
Eligibility Date	The next date employees and covered dependents can use NYS Vision Plan benefits. Covered employees and dependents over age 19, may use their benefits 24 months from their first covered service. Covered dependents under age 19, may use their benefits 12 months from their first covered service.
High Index Lenses	Lenses made from newer plastic materials that bend light more than the traditional plastic lenses. This results in lighter, thinner lenses, especially for those with strong prescriptions.
In-Network Benefits	Benefits obtained at a Davis Vision participating vision provider.
Intermediate Lenses	That area in a trifocal lens or lens blank that has been designed to correct vision at intermediate to distant ranges.
Lenticular Lenses	Lenses that are designed to reduce the weight and thickness and are used primarily for post-cataract lenses. The power is in the center of the lens but the edge is a portion of plain glass, so it is easily mounted in a frame.
Medical Exception Benefit	Special benefit program available for individuals with qualifying conditions such as diabetes, keratoconus, cataracts and other conditions that could cause a change in refractive status.
Ophthalmologist, or MD	A medical doctor who specializes in the eye. In addition to preventive eye care, ophthalmologists can prescribe medication for eye conditions and perform eye surgery.
Optician	Opticians sell and fit eyeglasses, sunglasses, and specialty eyewear. Opticians are not doctors but in most states must be licensed following specialized training.
Optometrist, or OD	An eye doctor who has completed four years of post-graduate optometry school. Optometrists examine eyes and can prescribe corrective eyewear.
Out-of-Network Benefits	Allowances reimbursed for services and materials obtained from vision providers who are not part of Davis Vision's Network.
Planned Replacement Contact Lenses	Soft lenses that are worn for a prescribed length of time, then are discarded.
Polaroid Lenses	Eyeglass lenses that block light reflected from horizontal surfaces such as water, in order to reduce glare.
Polycarbonate Lenses	Lenses made from a lightweight material 10 times more impact-resistant than other plastics. Recommended for children's eyewear and required in children's glasses in some states.
Progressive Lenses	Sometimes referred to as no-line bifocals, provide visual correction for distances and for up-close work.
Photosensitive Lenses	Lenses that change from transparent to tinted when exposed to ultraviolet light.
Standard Contact Lenses	Commonly used contact lens types defined as spherical clear contact lenses. These include disposable contact lenses, planned replacement lenses and others.
Specialty Contact Lenses	Contact lenses such as toric and multifocal lenses, which are not included in the standard contact lens selection.

Who To Contact

DAVIS VISION

Please contact Davis Vision with any questions or if you wish to:

- Verify eligibility
- Obtain a list of participating providers
- Obtain an out-of-network claim form
- Check the status of an out-of-network claim
- Recommend a provider for participation on the Davis Vision Network
- Obtain an identification card

General Address:	**Out-of-Network Claims Address:**
Davis Vision, Inc. 711 Troy Schenectady Road Latham, New York 12110	Davis Vision, Inc. Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110

Telephone: 888-588-4823 Fax: 518-220-6012
Website: Visit New York State Department of Civil Service website at https://www.cs.ny.gov. On the Civil Service home page, select Benefit Programs, then select NYSHIP Online and if prompted, choose your group and plan. Then select Other Benefits and then Vision Benefits and follow the links to the Davis Vision Website

HEALTH BENEFITS ADMINISTRATOR

Contact your agency Health Benefits Administrator if you wish to:

- Enroll in the Plan
- Notify the Plan of a change of address
- Add or remove a dependent
- If you, your spouse, domestic partner or a dependent loses eligibility for Vision Care coverage and would like to continue coverage under COBRA, or if you or your enrolled dependents have any questions regarding continuing coverage under COBRA

Agency Health Benefits Administrator:

_____

(fill in phone number)

or

Employee Benefits Division
NYS Department of Civil Service
Albany, NY 12239

Telephone:
In the Capital District Area: 518-457-5754
Outside the Capital District Area: 800-833-4344

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FOR INTERNAL USE ONLY

Auth #: _____

Paid ☐ Denied ☐ Pended ☐

Out of Network (Direct Reimbursement) Claim Form

Important Information:

1. Use this form to request reimbursement for services received from providers who do not participate in the Davis Vision network.
2. Expenses for both examinations and eyewear can be claimed on this form. Only services listed on this form will be considered for reimbursement.
3. **Make sure that all sections are completed, that you and the providers(s) have signed the form, and that all services, charges, and service dates have been entered. If the form is incomplete, additional information may be required. This may result in a delay of payment for eligible benefits.**
4. Please submit claim reimbursement for each patient on a separate claim form.
5. Please note that the **employee's** (or employee's authorized person's) signature is required on this form.
6. Mail completed claim form to: **Vision Care Processing Unit, P.O. Box 479, Troy, NY 12181.**
7. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage with your benefits office or call 1-888-588-4823 or visit https://www.cs.ny.gov. The patient is responsible for the costs of all treatment and materials provided.

Employee Information

(PLEASE PRINT CLEARLY)

Employee Name: _____ (First / Middle Initial / Last) Employee Identification No.: _____

Mailing Address: _____ (Street / City / State / Zip)

Business Phone: _____ (Area Code) Home Phone: _____ (Area Code)

Patient Information

Patient Name: _____ (First / Middle Initial / Last)

Relationship: ☐ Employee ☐ Spouse/Domestic Partner ☐ Child DOB: _____

Provider Information

Examiner

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

State License Number: _____

Phone Number: _____

Provider Signature: _____

Dispenser

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

State License Number: _____

Phone Number: _____

Provider Signature: _____

Service	Date of Service	Expense(s) Incurred
1. Eye Examination	(/ /)	$
2. Frames	(/ /)	$
3. Single Vision Lenses	(/ /)	$
4. Bifocal Lenses	(/ /)	$
5. Trifocal Lenses	(/ /)	$
6. Contact Lenses	(/ /)	$
7. Cataract S.V. Lenses	(/ /)	$
8. Cataract Bifocal Lenses	(/ /)	$
	Total	$

Employee Certification

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim to plan provisions. Additionally, I have read and understand the fraud statement on the back of this form.

Required

_____ _____

Employee or authorized person's signature **Date**

FRAUD STATEMENTS

Any person who knowingly and with intent to defraud and deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil and/or criminal penalties, which may include the payment of restitution, fines, imprisonment, loss of insurance and/or denial of benefits, depending upon state law.

In **Arizona**, for your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

In **California**, for your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

In **Florida**, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an insurance application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In **New Hampshire**, any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In **New York**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Kentucky**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

In **Minnesota**, a person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

In **Pennsylvania**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In **Puerto Rico**, any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than $5,000 and not more than $10,000, or a fixed term of imprisonment for 3 years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of 5 years, if extenuating circumstances are present, it may be reduced to a minimum of 2 years. Noncompliance will result in administrative fines. Failure to include this notice on the indicated forms shall not constitute a defense for the insured or the third party claimant.

For **Colorado**, **Maine**, **Tennessee**, **Virginia**, **Washington**, & **Washington, D.C.** residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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Authorization for Disclosure of Protected Health Information

This Authorization is Voluntary

Person Granting Authorization	Policy Holder Information
Date: _____	**ID Number:** _____
Name: _____	**Name:** _____
Address: _____	**Address:** _____
_____	_____
Date of Birth: _____	**Telephone:** _____

I authorize and direct Davis Vision, Inc. and its affiliates to furnish and release vision care insurance information regarding the person noted above.

Information to Be Disclosed:

____ Participating Vision Care Providers
____ Benefit, Policy and Procedure information
____ Vision Care Claims Information
____ Vision Care Claims Review Information
____ Eligibility Information
____ Other _____

Purpose of Disclosure:

____ To provide information to a family member or friend
____ As required for a legal matter
____ Other _____

Person(s) or Organization(s) To Receive the Identified Information:

Name: _____
Street Address: _____
City, State, Zip: _____
Name: _____
Street Address: _____
City, State, Zip: _____
Name: _____
Street Address: _____
City, State, Zip: _____

My protected health information is information about me, including information such as my name and address and/or medical information. The information was used or created when I received vision care or when payment was received for my vision care. The information may include my past, present or future vision health care or condition.

I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that my authorizing the use and disclosure of my "protected health information" is not a condition of my enrollment in the Davis Vision Care plan, my eligibility for benefits or payment of my claims.

Expiration: This authorization will expire on ____/____/____ or on occurrence of the following event _____

Right to Revoke: This authorization may be revoked at any time. Contact Davis Vision, Inc. Privacy Contact Office at 1-800-571-3366 for further instructions. Revocation of this authorization will not affect any action taken before Davis Vision, Inc. receives the notice of revocation.

Signature: _____ **Date:** _____
(Person requesting Authorization)

If this form is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____
(Please Print)

Description of Personal Representative Authority: _____

PLEASE RETAIN A COPY OF THIS SIGNED AUTHORIZATION FOR YOUR RECORDS

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM

Please read the instructions below before completing the Authorization form. The information you provide will be used to fulfill your request to disclose your protected health information and identify the person(s) who will be receiving your information. All required sections of the form must be completed in order for us to process this request. If required information is not completed, we will not disclose your protected health information. In certain circumstances, a written authorization to disclose your protected health information to a third party specified by the individual is required by law.

Section 1 - Member Information (Required)

This section must be completed with the information specific to the individual. A contact number or address is needed in case additional information or clarification is required.

Section 2 - Granting Authorization/Specification of Information to be Disclosed (Required)

Select the type of Protected Health Information to be disclosed. If OTHER, specify what information you wish disclosed.

Section 3 – Purpose of Disclosure (Required)

Select the purpose of this authorization to disclose Protected Health Information. If OTHER, specify the reason for the authorization.

Section 4 – Designate the Recipient(s) (Required)

Identify to whom the requested information is to be provided.

Section 5 – Important Information (Required)

Please read this section carefully.

Section 6 - Expiration/Revocation of an Authorization (Required)

You must indicate a date or event that will trigger the expiration of this authorization. Once an authorization has expired, the person who has been receiving your information will no longer be able to receive your information. If an event will trigger the expiration of this authorization, please indicate that event in the space provided.

Section 7- Signatures and Personal Representatives (Required)

The individual whose information is being disclosed must sign and date in the space provided. If this form is completed by your personal representative, he or she must include his or her name and relationship to you. (e.g. attorney-in-fact, guardian, executor, parent of a minor, etc.)

Please Return the Completed Authorization Form to the Address Below:

Davis Vision - Privacy Office
PO Box 479
Troy, NY 12181- 479
Telephone: 1-800-571-3366
Fax: 1-800-783-9046