VISION CLAIM FORM

Address: P.O. Box 6392, Grand Rapids, MI 49516-6392
Phone: (616) 464-6635
Fax: (616) 464-4458
E-mail: claimsubmit@asrhealthbenefits.com

Instructions:
1. Enter all requested information and sign the form.
2. Attach the itemized receipt from your provider.
3. Attach the Explanation of Benefits from other insurance, if applicable.
4. Submit the form and documentation to ASR via mail, fax, or e-mail.

Employee Information							
Name:			Date of Birth:				
Address:			City:			State:	ZIP:
Member Number (see ASR ID card):			Telephone Number:				
Employer's Name:			Employer's Group Number (see ASR ID card):				
Patient Information							
Name:			Date of Birth:				
Address:	☐ Same as Employee						
	☐ Other:						
Telephone Number:	☐ Same as Employee						
	☐ Other:						
Relationship to Employee:		☐ Self	☐ Spouse	☐ Child	☐ Other:		
Is the claim accident related?		☐ Yes	Date of Accident:				
		☐ No					
Do you have other vision insurance?		☐ Yes	Name of Carrier:			Policy Number:	
		☐ No					
Request for Reimbursement							
Exam: $	Contacts: $	Frame: $	Lens: $	☐ Single	☐ Bifocal	☐ Trifocal	☐ Progressive
Date of Service:			Provider Name:				
Certification							
I certify that these statements and answers are true to the best of my knowledge and belief. I understand that all vision benefits will be issued directly to the service provider unless written evidence/receipt is submitted to ASR showing that I paid the charges. I realize that I am financially responsible for the charges my Plan does not pay. I agree to reimburse the Plan for any overpayments in excess of what the Plan allows.							
X Employee Signature **(DO NOT TYPE OR PRINT)**:					X Date:		