

Capital Blue Cross (BlueCross Vision)
with National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015-2187



Re: PSECU Vision Plan Reimbursement Form

Vision Plan: ___ Standard Plan ___ Direct Reimbursement Plan

Subscriber Information

Subscriber Name: _____

Subscriber Social Security #: _____ - _____ - _____

Subscriber is the individual whose name the coverage is in. This could be the employee, retiree, or a COBRA participant.

Claim Information

<u>Patient Name</u>	<u>Date of Service</u>	<u>Type of Service</u>	<u>Cost</u>	<u>Provider</u>
John Doe	10/15/09	Exam, Lenses	\$187.00	Premier Eye
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Signature

Date

Attach Receipt

Mail or Fax claims as instructed below:

Mail Claims To:
National Vision Administrators
Claims Department
P.O. Box 2187
Clifton NJ 07015
Toll Free Line 1-800-905-4102

Fax Claims To: Fax:
(973) 574-2495 Attn:
Deborah Tyler