Vision Reimbursement Claim Form

motivhealth®

Complete the following and attach itemized statements. (Cash register receipts cannot be accepted.)

1. Employer/Group Name: _____

2. Employee's Name: Last: _____ First: _____

3. Employee's Mailing Address: _____

City: _____ State: _____ ZIP: _____

4. Phone Number: _____

5. Patient's Name: Last: _____ First: _____

6. Patient's Date Of Birth: _____

7. Does the patient have other vision coverage?: Yes ☐ No ☐

- Name of vision insurance company: _____
- Policy Number: _____
- Effective Date: _____

8. Payment for the attached claims should be made to:

Employee: _____ Provider: _____

I authorize the release of any medical information necessary to process the claim and request payment of benefits to either myself or to the provider as stated above. I certify the above information to be true to the best of my knowledge. I also understand that any misrepresentation may be cause for dismissal and/or nonpayment claims.

9. Employee Signature: _____ Date: _____

Mail completed form to:
MotivHealth
PO BOX 5 Smithfield, UT 84335

You may also fax or email claims as follows:
Fax: 435-563-4035 | Email: vision@motivhealth.com