Bluegrass Family Health

Vision Hardware Reimbursement Form

Instructions for use: Please use a separate form for each member requesting reimbursement. Please complete the following information and mail it along with receipt to: Bluegrass Family Health PO Box 22738 Lexington, KY 40522-2738. Please allow 6 – 8 weeks processing time.

Member Name____

ID#____

Mailing Address____
(Street or PO Box)

____
(City/State/ZIP)

Daytime Phone____

If not provided on the receipt, please include:

Diagnosis Code(s) ______________________________

Procedure Code(s)______________________________
(Your eye care physician can provide you with this information)

The attached receipt should include the following information:

- -Patient Name
- -Date of Service
- -Provider Name
- -Product Received
- -Cost of Product

Please note: Completion of this form does not guarantee payment. For questions regarding your vision benefit, please consult your Schedule of Benefits. You may also contact Customer Service at (800) 787-2680 Monday through Friday 8:30 am until 5:30pm EST.

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