SIMPLE
VISION PLAN

Vision Claim Submittal Form

Instructions: A separate form must be completed for each vision care visit. *All fields are required.* All payments will be paid to the member, which is normally the employee.

Steps:

Print and complete the form (please write clearly). Attach the detailed or itemized receipt.

The vision receipt must indicate the date of service, the "patient" name, the procedures/items purchased, and the cost of services.

Send the claim form and receipt to Simple:

a. By mail: Simple, Claim Processing Office, 2810 Premiere Pkwy, Ste. 400, Duluth, GA 30097
b. By fax to: 1-888-308-6009
c. By email: claims@Simple.us

Fax or email one form & receipt at a time.

Failure to follow these steps may cause the claim to not be processed.

Employee Last Name: _____ **First Name:** _____

Employer Name or Group Number _____

Employee SSN: _____ **or Member ID #** _____

Mailing Address for claim payment:

Name: _____

Street: _____

City: _____ **St:** _____ **Zip:** _____

"Patient" Last Name: _____ **First Name:** _____

Date of Birth: _____ **SSN:** _____ **or Member ID #** _____

Relationship to Employee: _____

(continued on next page)

Date of Visit: _____

Name of Vision Care Provider: _____

Item/Service Purchased:

1.	_____	Price: _____
2.	_____	Price: _____
3.	_____	Price: _____
4.	_____	Price: _____
5.	_____	Price: _____
6.	_____	Price: _____
7.	_____	Price: _____
8.	_____	Price: _____
9.	_____	Price: _____
10.	_____	Price: _____
11.	_____	Price: _____
12.	_____	Price: _____
13.	_____	Price: _____
14.	_____	Price: _____
15.	_____	Price: _____
Total:		Total: _____

You Must Attach An Itemized Submissions without an itemized receipt will