Mail To
Blue Benefit Administrators of Massachusetts
P.O Box 55917
Boston, MA 02205-5917
Fax To
877.596.2583

APPLICATION FOR **VISION MATERIALS OR OUT-OF-NETWORK PROVIDER** REIMBURSEMENT CLAIM FORM: This claim form must be accompanied by a copy of an itemized bill on provider letterhead to be eligible for plan reimbursement. You must complete each of the sections below.

SECTION I: EMPLOYEE INFORMATION		
NAME	SEX MALE FEMALE	DATE OF BIRTH
STREET ADDRESS	HOME PHONE NO.	
CITY, STATE, ZIP CODE	EMPLOYEE CARDHOLD NUMBER	

SECTION II: PATIENT INFORMATION			
NAME	DATE OF BIRTH	SEX MALE FEMALE	RELATION SELF SPOUSE DEPENDENT OTHER
STREET ADDRESS		HOME PHONE NO.	
CITY, STATE, ZIP CODE			

SECTION III: BENEFIT TYPE

SELECT FROM THE BELOW:

FRAMES LENSE(S) CONTACT LENSES FITTING ADJUSTMENT EXAM

AUTHORIZATION TO OBTAIN INFORMATION:

TO ALL PHYSICIANS, MEDICAL PROFESSIONALS, HOSPITALS, CLINICS, OTHER HEALTH CARE PROVIDERS, GROUP POLICYHOLDERS, INSURANCE SUPPORT ORGANIZATIONS, AND OTHER PERSONS WHO HAVE INFORMATION ABOUT THE PATIENT:

I AUTHORIZE YOU TO GIVE BLUE BENEFIT ADMINISTRATORS (BBA) ITS REINSURERS, OR ITS AGENTS: A) ALL INFORMATION YOU HAVE AS TO ILLNESS, MEDICAL HISTORY, DIAGNOSIS, TREATMENT, AND PROGNOSIS WITH RESPECT TO ANY PHYSICAL OR MENTAL CONDITION OF THE PATIENT; B)ALL EMPLOYMENT INFROMATION YOU HAVE ABOUT THE PATIENT; AND C) ANY OTHER INFORMATION YOU HAVE ABOUT THE PATIENT WHICH BBA BELIEVES IT NEEDS TO DETERMINE THAT THE PATIENT IS ELIGIBLE FOR BENEFITS UNDER A CONTRACT ADMINISTERED BY BBA AND/OR FOR ANY OTHER PURPOSE WHICH RELATES TO THE CONTRACT.

ANY BENEFITS PAYABLE ARE DUE TO THE (CHECK ONE): PROVIDER MEMBER

ELECTRONIC SIGNATURE OF EMPLOYEE DATE