CAMBRIDGE PUBLIC EMPLOYEES
DENTAL & VISION FUND

VISION BENEFITS CLAIM FORM

Before obtaining services, please verify eligibility by calling the Fund Office at 617-354-1110 or email visionclaim@cdvfund.org.

Please complete the following steps prior to submitting a claim form to the Fund Office. Any ineligible, incomplete or missing information may result in a claim being delayed or denied. Your claim must be submitted to the Fund Office **within one (1) year from the date of service in its entirety**. There is **NO reimbursement for exams, contact fittings, or non-prescription vision materials**.

1. **Must include an itemized paid bill** that indicates the date of service, patients name, provider(s) information, services received, and amount charged for each item – lenses, frames, or contacts. Must be paid with **no outstanding balance due**.
2. Attach **verification of payment** – receipts, charge slips, copy of cancelled check, or credit card/bank statement. The words **"Paid In Full"** written, stamped, etc. on the itemized bill are not acceptable as verification of payment.
3. A separate claim form must be completed for the member and/or dependent(s) requesting reimbursement.
4. Only **one (1) claim submission** will be allowed for each 24-month eligibility period or for each 12-month period for dependent children under age 14.
5. If purchasing more than one (1) combination of lenses, frames, and/or contacts it **must be purchased within 30 days of the first purchase**. Any portion of the allowable $450 benefit that is not utilized within the 30 days may not be carried over.
6. Sign and date claim form, and submit by mail or email.

   Mailing Address: Cambridge Public Employees Dental & Vision Fund
   125 CambridgePark Drive, Suite 104
   Cambridge, MA 02140

   Email Address: **visionclaim@cdvfund.org**
7. To submit claims by email you must scan (**pdf format only**) and attach claim form, itemized bills and receipts. **Photo images will not be accepted**.

MEMBER INFORMATION (SUBSCRIBER) *PLEASE PRINT CLEARLY*

FIRST NAME	LAST NAME

LAST 4 DIGITS OF SSN	DATE OF BIRTH	HOME PHONE	OTHER PHONE
XXX – XX –			

STREET ADDRESS	IS THIS A NEW ADDRESS: YES ☐ NO ☐

CITY	STATE	ZIP CODE	STATUS
			EMPLOYEE ☐ RETIREE ☐

DEPARTMENT: ACTIVE EMPLOYEE	EMAIL, IF HAVE ONE

COMPLETE INFORMATION IF CLAIM IS FOR DEPENDENT (SPOUSE/CHILD) *PLEASE PRINT CLEARLY*

FIRST NAME	LAST NAME

RELATIONSHIP TO MEMBER	DATE OF BIRTH	
SPOUSE ☐ CHILD ☐		**DISABLED DEPENDENT VERIFICATION** REQUIRED FOR DEPENDENT CHILDREN AGE 26 OR OLDER → CHECK IF DISABLED DEPENDENT ☐

SIGN AND DATE FORM

MEMBER SIGNATURE	TODAY DATE

The Board of Trustees may suspend or, in some case, terminate the vision benefits of any person who files a claim containing any misrepresentation or any false, incomplete, or misleading information. I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any provider named to disclose all known facts concerning this claim. A copy or photocopy of this authorization shall be as valid as the original.

OFFICE USE ONLY

RCD	FUND#	UC#	DEPT	LDS