mint. Health Plans

Vision Reimbursement Claim Form

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 of claims.

9.Employee Signature: _____Date:_____

Mail completed form to: **Mint Health Plans**
PO Box 36, Smithfield UT 84335

You may also fax or email your claim as follows:
Fax claims to: 435-563-4035 | Email: vision@benefit-support.com