



VISION MEMBER CLAIM FORM

Fill out a separate form for each member submitting claims for covered services.
See instructions below for submission.

Employee Information

Employer	SSN or ID #
Name	Date of Birth
Address	
Phone Number(s)	Other
Email	

Patient Information

Patient Name	Relation to Subscriber	<input type="checkbox"/> Spouse	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> Other
Date of Birth					
Is this request related to a work accident or injury?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Injury		
Is this claim related to a medical emergency?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Emergency		

Claim Information

Claim	Name of Member	Date(s) of Service	Description of Service(s)	Diagnosis/Illness (if applicable)	Total Charges	Amount Paid by You
1						
2						
3						
4						
Total Claims Reimbursement						

Other Health Insurance – Policyholder Information

This section only needs to be completed if the patient was/is covered by other insurance (including Medicare) at the time of the claim.

Name of Policyholder	
Date of Birth	Individual to Receive Reimbursement:
Policyholder Employer	
Employer Address	
Other Vision Carrier	Other Policy Number
Relation to Subscriber	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other
	Forms Prepared by

Form Submission

Phone: (888) 326-2555

Secure Fax: (916) 467-1401

Mailing Address: BRMS Claims
P.O. Box 2140
Folsom CA 95763

Instructions:

- Enclose a **copy of all bills AND proof of payment** for reimbursement.
- Verify that bills contain the date and description of service, the amount, and the provider's name stamped on receipt.
- Sign your claim form.**
- Submit claim form** to BRMS mailing address above.
- Call** the phone number above if you have any questions.
- BRMS may request further information if necessary to process your claim according to IRS guidelines.

Acceptable Documentation includes the following:

- a.) Explanation of Benefits (EOB) from insurance carrier
- b.) Itemized Statement or bill from your provider which includes:
 - Provider name
 - Patient name
 - Description of service
 - Original date of service (the date of service, not the date of payment, must fall within the plan year for which you are currently enrolled)
 - Patient portion of charge(s)

Employee Signature _____

Date _____