luminare health℠

Experience. Solutions. Results.

VISION CLAIM FORM – VIBRANTCARE REHABILITATION, INC. GROUP #KD0000

INSTRUCTIONS FOR COMPLETING FORM
1) Be sure to answer all questions to avoid delay. 2) Complete Part A, being sure to sign and date the form in each of the appropriate spaces. 3) Send or fax claim to address/fax number listed below.

Please attach all itemized bills/receipts pertaining to this claim.

PART A – TO BE COMPLETED BY EMPLOYEE		
NAME OF EMPLOYEE (PRINT LAST NAME FIRST)	EMPLOYEE'S BIRTH DATE	SOCIAL SECURITY #
HOME ADDRESS	CLAIM IS MADE FOR ☐ MYSELF ☐ SPOUSE ☐ CHILD	Provider Tax ID #
PATIENT'S NAME	PATIENT'S DATE OF BIRTH	

AUTHORIZATION TO RELEASE BENEFITS	
I certify that the above statements and answers, including any accompanying bills and statements are true and complete to the best of my knowledge and belief. I authorize the release to and the use by Luminare Health of any medical or other information needed in processing this claim. A photocopy of this authorization shall be as valid as the original.	
SIGNATURE OF EMPLOYEE	**GROUP #KD0000**
Make check payable to: ☐ Employee ☐ Provider: Provider Address:	Date

PLEASE MAIL CLAIM STATEMENT TO:

Luminare Health
PO Box 2920
Clinton, IA 52733-2920

OR FAX CLAIM STATEMENT TO: *1-877-411-5964*

*OR EMAIL CLAIM STATEMENT TO: medicalfax2@luminarehealth.com
must put VibrantCare Rehabiliation Center Vision Claim Statement in the subject line