Vision Benefit Claim Form

Please complete and return to:
POMCO
P.O. Box 6329
Syracuse, NY 13206
MyPOMCO.com

Section 1. Member Information.			
Member Identification Number (located on your POMCO ID card):		Phone Number:	
Last Name:	First Name:	Middle Initial:	Date of Birth:
Address:		New Address: ☐ Yes ☐ No	
City/State/Zip:	I prefer to be contacted by: ☐ Email: _____ ☐ Phone: _____ or ☐ Mail (we will use the address provided above)		
Employer Name:		Plan Number (located on your POMCO ID card):	
Spouse Last Name:	Spouse First Name:	Middle Initial:	Spouse Date of Birth:

Section 2. Patient Information.				
Last Name:	First Name:	Middle Initial:	Date of Birth:	
Address: ☐ Check if same as enrollee		City:	State:	Zip Code:
Relationship to Subscriber:	Full-Time Student: ☐ Yes ☐ No	School Name:	School Phone Number:	

Section 3. Accident Information. Please include additional paper if necessary.		
Workplace Accident: ☐ Yes ☐ No	Auto Accident: ☐ Yes ☐ No	Date Accident Occurred:
How did the accident occur?		

Section 4. Provider Information.			
Vision Care Provider's Name: First:	MI:	Last Name:	
Vision Care Provider's Facility Name			
Vision Care Provider's Mailing Address: Street:	City:	State:	Zip:
Items for Reimbursement (check all that apply): ☐ Eye Exam	☐ Frames	☐ Lenses	☐Contact Lenses

Section 5. Acknowledgement. My signature authorizes the release of my information or the information of my minor child under the age of 18 years old only. Any person who knowingly and with intent to defraud any vision plan files any materially false information, or conceals for the purpose of misleading, may be committing a crime and may be subject to a civil penalty for each violation. I certify that the above information is true to the best of my knowledge. In addition, my signature authorizes any vision or health care provider to provide pertinent records to POMCO, upon request including records for any illness or condition needed (including mental illness and/or AIDS/HIV) to evaluate claims.

Also, by signing this form, I am certifying that health reimbursement arrangement (HRA) funds were not used to pay for services and supplies at the point of sale. I understand that I may not seek vision plan reimbursement for HRA payments made for vision services and supplies.

Signature:	Date:

Section 7. Claim Substantiation Submission Guidelines.

- Clip, do not staple, all original itemized bills and receipts to this completed form and mail them to POMCO
- Make sure all bills and receipts indicate the services performed, products purchased, date of service, and cost.
- Submit all claims to POMCO in a timely manner.
- Be sure to notify your employer of all address changes.
- Please include your member identification number on all documents.