



Block Vision

NON-PARTICIPATING PROVIDER REIMBURSEMENT PROCEDURE

IF YOU ARE IN AN AREA THAT DOES NOT HAVE A PARTICIPATING PROVIDER OR YOU CHOOSE NOT TO USE A PREFERRED PROVIDER, PLEASE FOLLOW THE PROCEDURE OUTLINED BELOW:

1. Select a provider.
2. Attach an itemized statement or receipt to this form.
3. Complete the following information:

Employee Name	_____
Employee SSN	_____
Home Address	_____ _____
Patient Name	_____
Patient SSN	_____
Plan Number	_____
Employer	_____

4. Mail this form and your statement/receipt to Block Vision at:

Block Vision, Inc.
P.O. Box 14035
Milwaukee, WI 53214-0035

Phone # 866-265-0517
Fax # 888-288-6930