Combined Insurance Services
INCORPORATED

VISION CLAIM FORM

REMIT TO:
Combined Insurance Services, Inc.
P.O. Box 2438, Ocala, Fl 34478

800-473-2181
352-237-2040 Fax
Email: *william@combinedinsuranceservices.com*
www.combinedinsuranceservices.com

CLAIM INFORMATION
EMPLOYEE SECTION

EMPLOYER:_____

NAME OF EMPLOYEE:_____ **DATE OF BIRTH:**_____

EMPLOYEE ID#:_____ **PHONE NUMBER:**_____

EMPLOYEE ADDRESS: _____

NAME OF DEPENDENT & RELATIONSHIP (IF PATIENT):_____

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DIRECTIONS FOR FILING A CLAIM:

1. FILL OUT THE CLAIM FORM ABOVE
2. ATTACH YOUR BILL OR A LEGIBLE COPY TO THIS CLAIM FORM
3. MAIL OR FAX THE BILL AND CLAIM FORM TO COMBINED INSURANCE AT THE FOLLOWING ADDRESS:

COMBINED INSURANCE SERVICES, INC
P.O. BOX 2438
OCALA, FL 34478

FAX: 352-237-2040
ATTN: CLAIMS DEPARTMENT