

CIGNA ROUTINE VISION CARE REIMBURSEMENT FORM

WESLEYAN UNIVERSITY
Account # 3188942

Employee Name: _____

Employee ID#: _____

Patient Name: _____

Patient DOB: _____

Date of Service: _____

Indicate those services performed by placing a check mark on the line

- **Eye Exam:** _____ (one per calendar year at no charge)

Hardware - per calendar year:

- **Eyeglasses:** _____ (Eyeglasses including lenses & frames \$75)
- **Contact Lenses:** _____ (Contact lenses \$75)

Employee Address: _____

Employee Phone#: _____

Employee Signature: _____

Please include a copy of all receipts with this form

Write your name and ID# on ALL bills and receipts submitted.
You must include an itemized receipt which includes the name, address, phone number, tax identification number of the provider, date of service and procedure/diagnosis codes.

Mail to:

CIGNA HealthCare
32 Valley Street
Bristol, CT 06010
ATTENTION: Wesleyan Vision Claim Unit