Superior Vision Services, Inc.

Non-Network Claim Form

Top section to be completed in full.

Employee/Insured Name		**Daytime Phone** ( )	**Evening Phone** ( )	
Mailing Address		**City**	**State**	**Zip**
Social Security Number	**Authorization Number**	**Name of Employer**		

Dependent Information. Complete the address and telephone numbers only if different from the above.

Name of Dependent (only if filing the claim)		**Daytime Phone** ( )	**Evening Phone** ( )	
Mailing Address		**City**	**State**	**Zip**
Social Security Number	**Authorization Number**	**Date of Birth**	**Full Time Student (over 18 yrs)*** ☐ **Yes** ☐ **No** ***Verification may be required**	

Mail original itemized invoice or receipt that is imprinted with the providers name and address to:

Superior Vision Services, Inc.
P. O. Box 967
Rancho Cordova, CA 95741
800-507-3800