DAVIS VISION
EYECARE REFRAMED℠

Provider Request for Claim Appeal/Reconsideration Review

Do not attach claim forms unless changes have been made to the original claim that was submitted. Please attach supporting documentation to facilitate your review. This form must be the first page of the correspondence you are submitting.

Reason for Appeal Review (if additional space is required, use the back of this form or attach the additional material). Please include detailed information as to the nature of your claim appeal/reconsideration review request. If a corrected claim has been attached, please specify revisions that were made:

Please submit to the following contact:

Davis Vision
Complaints and Appeals Department
P.O. Box 791
Latham, NY 12110
Fax: 1-888-778-1008 Email: ProviderCA@davisvision.com

Claim Data:

Member ID Number:	
Member Name:	
Patient's Name:	
Date of Service:	
Billed Amount:	
Authorization Number:	

Provider Data:

Provider Number:	
Provider Name:	
Provider Address:	
Contact Person:	
Telephone Number:	