



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): _____

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