BAPTIST HEALTH PLAN®

VISION HARDWARE REIMBURSEMENT FORM

Please use a separate form for each member requesting reimbursement.
Complete the following information and mail it along with receipt to:

Baptist Health Plan
PO Box 22738
Lexington, KY 40522-2738
Please allow 6–8 weeks processing time

Member name: _____

ID: _____

Mailing address: _____
Street or PO Box

City: _____ **State:** _____ **ZIP:** _____

Daytime phone: _____

The attached receipt should include the following information:

- Patient Name
- Date of Service
- Provider Name
- Product Received
- Cost of Product

Completion of this form does not guarantee payment.

For questions regarding your vision benefit, please refer to your Schedule of Benefits.
You may also contact Customer Service at 800.787.2680, Monday-Friday 8:30 a.m. - 5:00 p.m. EST.