VISION CLAIM REIMBURSEMENT FORM

Name:_____ Phone Number:_____

Social Security Number or Member ID:_____

Mailing Address:_____

New Address: ☐ Yes ☐ No

Please provide the following information:

Name of employee or dependent receiving services _____

Date services rendered _____**Total** _____

****please include an itemized statement for these services****

Mail this form with an itemized statement to:
AmeriBen/IEC Group - P.O. Box 7186 - Boise, Idaho 83707
Or by email to Mmaciel@ameriben.com

If you have any questions for completing this form, please feel free to call Monique Maciel (208) 955-1391

www.myameriben.com