



*VillageHealth® (HMO-POS)*  
OPTICAL SERVICES REIMBURSEMENT FORM

Please provide the following information:

Member Name: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Member Date of Birth: \_\_\_\_\_

Member Address: \_\_\_\_\_

\_\_\_\_\_

*Please attach the itemized bill for your glasses, or  
contact lenses to this form and mail to:*

VillageHealth Claims Department  
P.O. Box 22698  
Long Beach, CA 90801

If you need assistance, or if you have any questions regarding the completion of this form, please call the VillageHealth Member Services Department at 1-877-586-1648. We are available to help you between the hours of 7:00 a.m. – 8:00 p.m., seven days a week. TTY users may call 1-866-525-7833. A VillageHealth representative will be happy to assist you.

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