GRCC
GRAND RAPIDS COMMUNITY COLLEGE

RESET

PRINT

SUBMIT CLAIM TO

ASR CORPORATION
P.O. BOX 6392
GRAND RAPIDS, MI 49516-6392
claimsubmit@asrhealthbenefits.com
Fax: (616) 464-4458

GROUP #692

DO NOT WRITE IN SHADED AREAS

VISION REIMBURSEMENT CLAIM FORM

PATIENT NAME	RELATIONSHIP TO EMPLOYEE			SEX	BIRTHDATE	DATE	Location Code
ONE NAME PER CLAIM FORM	(CIRCLE) - Self Spouse Child	OTHER		(CIRCLE) - Male Female			
EMPLOYEE NAME	EMPLOYEE SOCIAL SECURITY NUMBER			GL#			
Last First Middle							
	PAYMENT DESCRIPTION						
Address:	VISION REIMBURSEMENT						
				AMOUNT TO BE PAID			
CITY STATE ZIP				$			

***COMPLETE THIS SECTION IF PATIENT IS COVERED BY ANOTHER PLAN**	**Subscriber Name**	**Social Security Number**	**Name and Address of Employer**
	Plan Name	**Group Number**	**Name and Address of Carrier**

***If you are covered by another plan, please submit documentation from other plan that eligible charges were processed (e.g., an EOB).**

DATE OF SERVICE	DESCRIPTION OF SERVICE	PROCEDURE CODE (if available)	$AMOUNT
		SUBTOTAL	
		LESS AMOUNT PAID BY OTHER INSURANCES	
		LESS DISCOUNTS	
		TOTAL	

DOCTOR NAME OR SERVICE PROVIDER TELEPHONE

I HEREBY CERTIFY:

1. That the above is a true report of expenses paid by myself, not having been reimbursed from another source
2. That the patient indicated is either myself, my spouse, or my eligible dependent children.
3. That I grant permission to contact my doctor for clarification of the billing statement attached.

NOTE: Be advised that any person knowingly and with intent to injure, defraud or deceive Grand Rapids Community College in filing incomplete or misleading information may be guilty of a criminal act punishable under law. Grand Rapids Community College reserves the right to determine its own level penalty up to and including discharge.

Employee Signature _____ Signature Required

Employee Bargaining Group _____

ATTACH ITEMIZED BILL AND PROOF OF PAYMENT

rev. 02/15

Grand Rapids Community College
Dental & Vision Claim Submission Process

Please carefully follow the steps listed below to file a claim under this plan:

STEP 1 The Employee must pay the full cost of Covered Expenses for dental or vision care. **NOTE: If the Participant does not have other dental of vision plan coverage, the Participant can proceed to step 4. If the Participant has other coverage, he or she must continue with steps 2-5.**

STEP 2 File a claim for dental or vision care expenses with any other dental or vision plan under which coverage was elected (e.g., dental or vision coverage under a spouse's employer's group health plan).

STEP 3 Obtain documentation from the other dental or vision plan that eligible charges were processed and that a balance on the charges remains outstanding (e.g., an EOB).

STEP 4 Obtain the Grand Rapids Community College (GRCC) Dental or Vision Reimbursement Form. Complete all of the requested information. This claim form is available at the GRCC HR/Benefits Office or Online at http://grcc.edu/humanresources/healthbenefits. If you need assistance contact the GRCC HR/Benefits Office at (616) 234-4175 or (616) 234-4052.

STEP 5 Sign and date the claim form where indicated, attach the EOB from the other health plan, if any, attach a copy of the itemized bill or invoice, attach evidence of payment, and then submit all to ASR via one of the following methods:

Mail: ASR Corporation P.O. Box 6392 Grand Rapids, Michigan 49516-6392
Email: claimsubmit@asrhealthbenefits.com
Fax: (616) 464-4458

Participants should submit claims for reimbursement within 60 days from the date of service.

Questions?

Call ASR Health Benefits Monday-Friday 8 am to 4:30 pm

Employees with last name beginning A-L
Contact: Claims Analyst-Marcie B: (616) 957-1751, extension 3093

Employees with last name beginning M-Z
Contact: Claims Analyst-Sue L: (616) 957-1751, extension 3013