Eye care professional request for claim appeal / reconsideration review

Do not attach claim forms unless changes have been made to the original claim that was submitted. Please attach supporting documentation to facilitate your review. This form must be the first page of the correspondence you are submitting.

Reason for appeal review

Please include detailed information as to the nature of your claim appeal/reconsideration review request. If a corrected claim has been attached, please specify revisions that were made. If additional space is required, use the back of this form or attach the additional material.

Please submit to the following contact:

Davis Vision
Complaints and Appeals Department
P.O. Box 791
Latham, NY 12110

Fax: 1 (888) 778-1008, Email: **providerca@versanthealth.com**

Claim data

Member ID number	
Member name	
Patient's name	
Date of service	
Billed amount	
Authorization amount	

Provider data

Provider number	
Provider name	
Provider address	
Contact person	
Telephone number	