avēsis | UnityPoint Health

Avēsis Direct Reimbursement Claim

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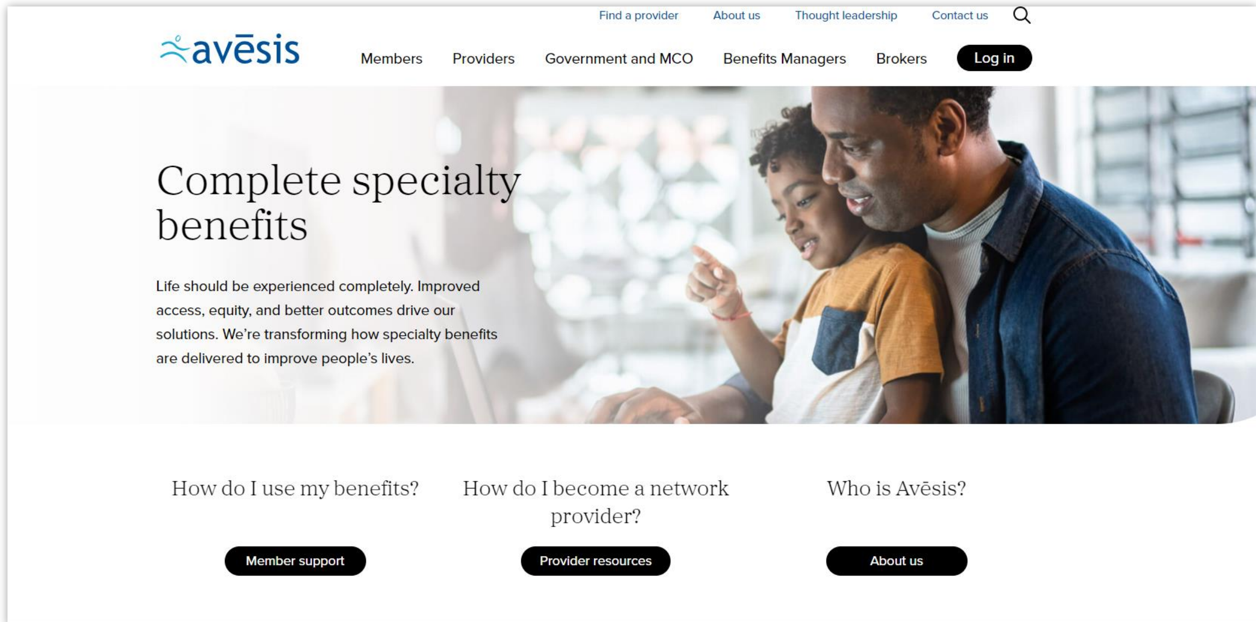
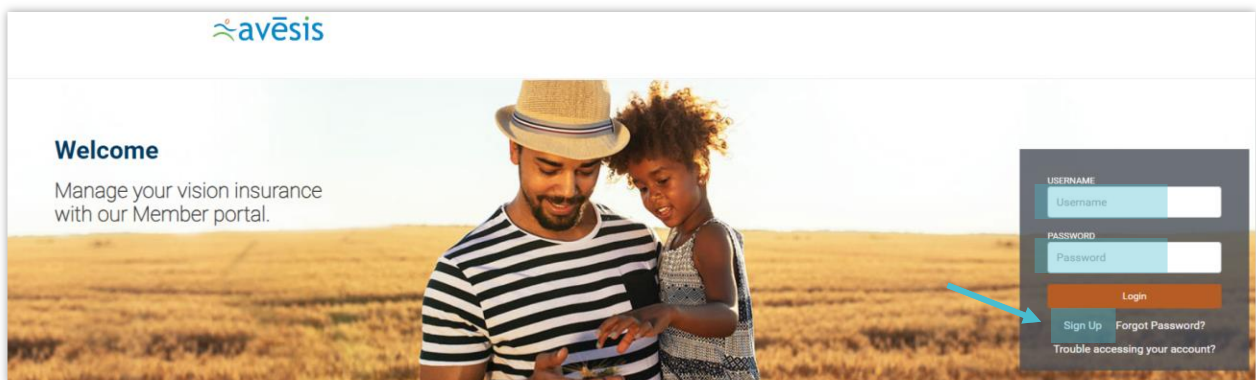
How to File Avēsis Direct Reimbursement Claim Online

1. Login at www.avesis.com.

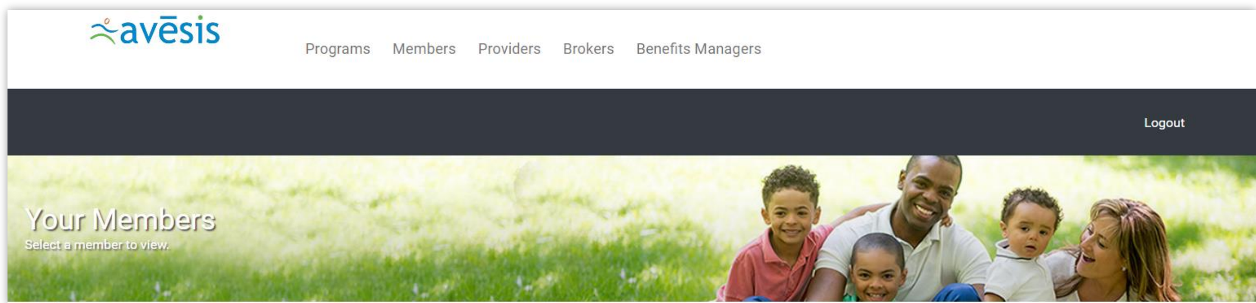


2. Click on the **Members** tab to see the dropdown and click on **Member Portal**.

3. Once on the member portal either choose Sign-up or enter your **Username** &**Password**.



4. Once you have logged in you will need to choose a listed member to be taken to the Dashboard.



5. The choose **Member Direct Reimbursement Claim Submission**.

Dashboard
Welcome back, Kara

ONLINE EYEGLASS ORDERING
Place frame orders online

FIND A VISION PROVIDER
Ready to visit a Vision provider? Start your search here.

CHECK YOUR VISION ELIGIBILITY
Is it time for an exam or new materials? Check to see if you are eligible for benefits.

VIEW YOUR VISION BENEFITS
Want to know what is covered under your vision plan? View your summary of benefits.

VISION CLAIM STATUS
Check your Vision claims summary explanation.

PRINT AN ID CARD
Download and print your ID card.

MESSAGE CENTER
Alerts and announcements.

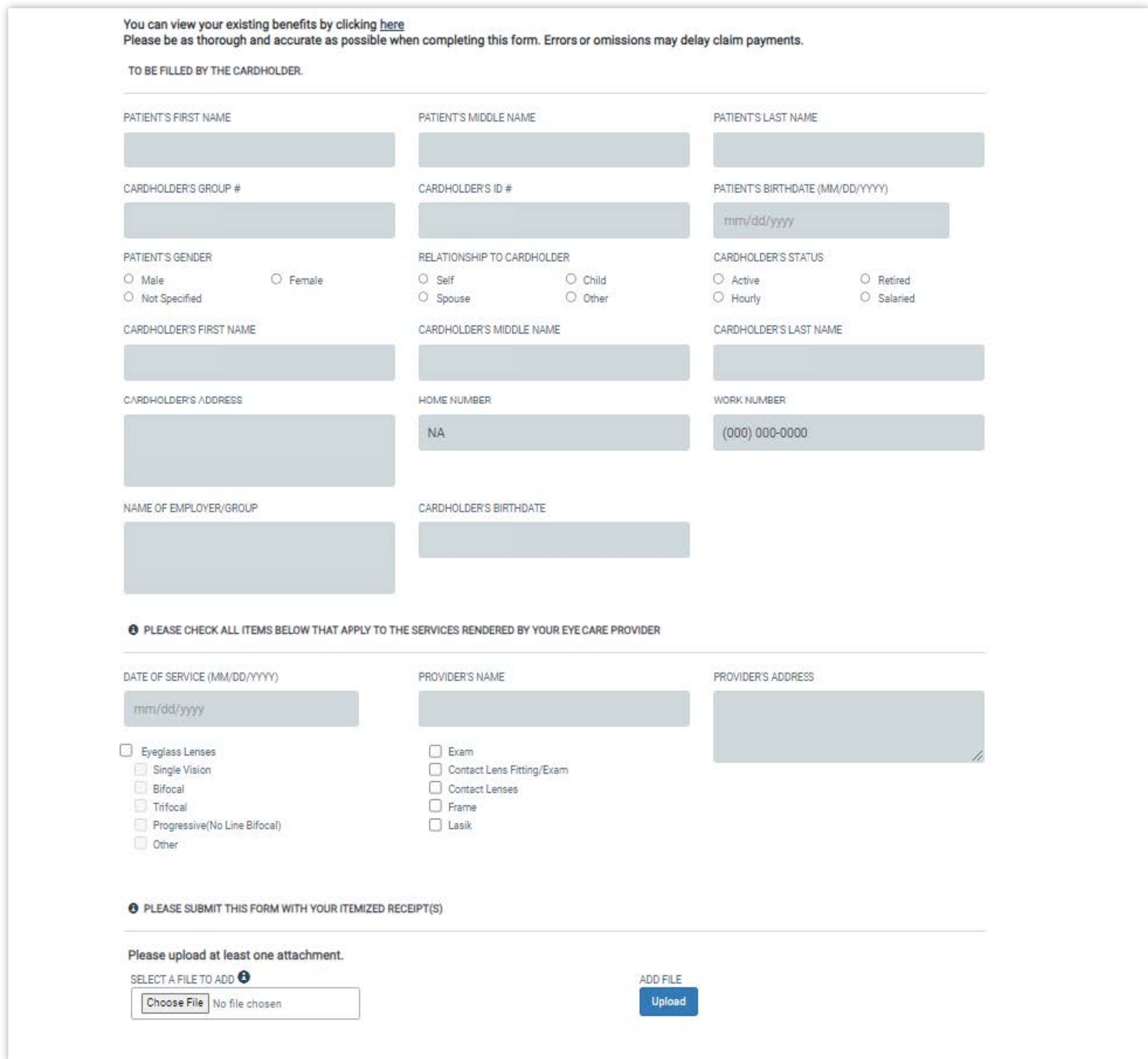
EDIT YOUR PROFILE
Update your Security Questions or change your password.

VIEW MEMBERS
Select another member under your plan to view.

VIEW FORMS AND DOCUMENTS
Access the List of Documents

MEMBER DIRECT REIMBURSEMENT CLAIM SUBMISSION
Submit a claim for direct reimbursement

6. Complete all fields on form, upload receipt and submit.



You can view your existing benefits by clicking here
Please be as thorough and accurate as possible when completing this form. Errors or omissions may delay claim payments.

TO BE FILLED BY THE CARDHOLDER.

PATIENT'S FIRST NAME
PATIENT'S MIDDLE NAME
PATIENT'S LAST NAME
CARDHOLDER'S GROUP #
CARDHOLDER'S ID #
PATIENT'S BIRTHDATE (MM/DD/YYYY)
mm/dd/yyyy
PATIENT'S GENDER
Male
Female
Not Specified
RELATIONSHIP TO CARDHOLDER
Self
Child
Spouse
Other
CARDHOLDER'S STATUS
Active
Retired
Hourly
Salaried
CARDHOLDER'S FIRST NAME
CARDHOLDER'S MIDDLE NAME
CARDHOLDER'S LAST NAME
CARDHOLDER'S ADDRESS
HOME NUMBER
NA
WORK NUMBER
(000) 000-0000
NAME OF EMPLOYER/GROUP
CARDHOLDER'S BIRTHDATE

PLEASE CHECK ALL ITEMS BELOW THAT APPLY TO THE SERVICES RENDERED BY YOUR EYE CARE PROVIDER

DATE OF SERVICE (MM/DD/YYYY)
mm/dd/yyyy
PROVIDER'S NAME
PROVIDER'S ADDRESS
Eyeglass Lenses
Single Vision
Bifocal
Trifocal
Progressive(No Line Bifocal)
Other
Exam
Contact Lens Fitting/Exam
Contact Lenses
Frame
Lasik

PLEASE SUBMIT THIS FORM WITH YOUR ITEMIZED RECEIPT(S)

Please upload at least one attachment.
SELECT A FILE TO ADD
Choose File No file chosen
ADD FILE
Upload