EYEWEAR REIMBURSEMENT REQUEST FORM

MEMBER INFORMATION	
Name:	Date of Birth:
Address:	
Member ID:	
Medical Group/IPA:	Coastal Communities Physician Network
Date of Purchase:	

REIMBURSEMENT INFORMATION
Amount Paid:
Type (select one): ☐ Frames ☐ Contacts

PROOF OF PAYMENT
Proof of payment **is required** and must be attached for timely processing. Examples of proof of payment include: • Provider statement that shows a payment made • Copy of official receipt that shows itemized purchases

SIGNATURE OF MEMBER	
Print Name	
Signature	Date

Mail this form and proof of payment to:

Coastal Communities Physician Network
PO Box 13518
Bakersfield, CA 93389

Three-week processing time for reimbursement check issuance. If you have any questions regarding your request, please contact CCPN Customer Service at (800) 763-7732.

GSIR-20-042

*For Golden State Medicare Health Plan beneficiaries only