PIOPAC Fidelity
Third Party Administration
"Security, Integrity, Trust"

Vision Insurance Claim Form

Participant name (*Please type or print*): _____ **Last 4 Digits of Social Security #:** _____

Participant Address (*complete only if **new***): _____
City State Zip

Employer _____

Daytime Phone: _____ **E-mail:** _____

By submitting this claim form, I certify and warrant to PIOPAC Fidelity that these services I or my dependents have incurred.

=>Participant Signature: _____ **Date**: _____

LIST EACH CLAIM SEPARATELY

Patient Name (A)	Provider Name (B)	Description of Service (C)	Dates of Service (D)	Claim Amount	PIOPAC Use Only

TO SUBMIT YOUR COMPLETED FORM:

FAX completed Insurance Claim form to: **(808) 536-0430**
Note: Use discretion when faxing your personal medical information. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to PIOPAC.

EMAIL completed request for reimbursement forms to: fsaclaims@piopac.com
OR
MAIL completed request for reimbursement forms to:

PIOPAC Fidelity
Claims Dept.
1164 Bishop Street, Suite 1200
Honolulu, HI 96813

For Customer Service call: (808) 792-5226

FOR OUT-OF-POCKET EXPENSE NOT COVERED BY PLAN, YOU MUST USE THE REQUEST FOR REIMBURSEMENT FORM