

Vision Plan Out-of-Network Claim Form

Please complete the employee and patient information

Today's date		Date of service	
Employee's name		Employee's unique identification number	
Address where check should be mailed			
Address			
City		State	ZIP
Patient's name	Patient's relationship to employee (check one) <input type="checkbox"/> Self <input type="checkbox"/> Dependent		Patient's date of birth

Please complete services and materials received. You must provide the costs paid. Costs paid must match submitted receipt(s).

Please Note: Receipts must be submitted together at the same time for services and materials purchased (even if purchased on different dates) to receive reimbursement. You will receive a one-time reimbursement based on your service frequency in your employer's vision care plan.

Exam	
<input type="checkbox"/> Eye / Vision Exam	Paid: \$

Complete below for glasses	OR...	Complete below for contacts
Glasses		Contacts
<input type="checkbox"/> Frames	Paid: \$	<input type="checkbox"/> Contact fitting/Exam
Glasses lens type (Check only one)		<input type="checkbox"/> Contact lenses
<input type="checkbox"/> Single-vision lenses	Paid: \$	Note: Contact fitting fees must accompany contact lenses purchased.
<input type="checkbox"/> Bi-focal lenses	Paid: \$	
<input type="checkbox"/> Tri-focal lenses	Paid: \$	
<input type="checkbox"/> Lenticular lenses	Paid: \$	
Employee signature		Date

Please return this form with a copy of your paid, itemized receipt to:

UnitedHealthcare Vision
 ATTN: Claims Department
 P.O. Box 30978
 Salt Lake City, UT 84130
 Fax: (248) 733-6060

Questions? You can call our Customer Service Department at (800) 638-3120

