



Vision Plan Out-of-Network Claim Form

Please complete for provider 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="radio"/> Self <input type="radio"/> Dependent	Patient's Date of Birth

Please complete services and materials received. You must provide the exact paid check amount (make certain on check).

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 FEDVIP vision care plan.

Exam

Eye / Vision Exam Paid: \$

Glasses		Contacts	
<input type="radio"/> Frames	Paid: \$	<input type="radio"/> Contact Fitting / Exam	Paid: \$
Glasses Lens Type (Check only one)		<input type="radio"/> Contact Lenses	Paid: \$
<input type="radio"/> Single-vision lenses	Paid: \$	Note: Contact fitting fees must accompany contact lenses purchased. If service(s) received from an in-network provider, please include provider's National Provider Identification Number (NPI):	
<input type="radio"/> Bi-focal lenses	Paid: \$		
<input type="radio"/> Tri-focal lenses	Paid: \$		
<input type="radio"/> 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