

Vision Plan Out-of-Network Claim Form

Today's Date		Date of Service	Date of Service	
Primary Insured's Name			First 5 digits of the Primary Insured's Social Security Number OR 9-digit Member ID Number	
Add	lress where check should	d be mailed		
Add	ress			
City	,		State ZIP	
Pati	ent's Name		Patient's Relationship to Employee (check one) OSelf ODependent	Patient's Date of Birth
PΙΔ	ase complete services	and materials receiv	ed. You must provide the costs paid	l.
	ts paid must match sub	omitted receipt(s).		
Plea on o	se Note: Receipts must be	e submitted together at reimbursement. You w	the same time for services and materi Il receive a one-time reimbursement ba	als purchased (even if purchased ased on your service frequency
Plea on o	ise Note: Receipts must be different dates) to receive our employer's vision care	e submitted together at reimbursement. You w	the same time for services and materi Il receive a one-time reimbursement ba	als purchased (even if purchased ased on your service frequency
Plea on c in ye	use Note: Receipts must be different dates) to receive our employer's vision care	e submitted together at reimbursement. You w	the same time for services and materi Ill receive a one-time reimbursement ba	als purchased (even if purchased ased on your service frequency
Plea on coin ye	se Note: Receipts must be different dates) to receive our employer's vision care	e submitted together at reimbursement. You w e plan. Paid: \$	the same time for services and material receive a one-time reimbursement be complete below for contact.	sed on your service frequency
Plea on c in ye	ise Note: Receipts must be different dates) to receive our employer's vision care Eye / Vision Exam	e submitted together at reimbursement. You w e plan. Paid: \$	II receive a one-time reimbursement ba	sed on your service frequency
Plea on c in ye	ise Note: Receipts must be different dates) to receive our employer's vision care m Eye / Vision Exam nplete below for glasse	e submitted together at reimbursement. You w e plan. Paid: \$	Complete below for conta	ased on your service frequency
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Pleason Coin your Example Coording of the Coordina of the Coor	ise Note: Receipts must be different dates) to receive pur employer's vision care im Eye / Vision Exam inplete below for glasses Frames sses Lens Type (Check of Single-vision lenses Bi-focal lenses	e submitted together at reimbursement. You we plan. Paid: \$ Paid: \$ nly one) Paid: \$ Paid: \$	Complete below for contacts Contacts Contact Fitting / Exact Contact Lenses Note: Contact fitting contact ler	m Paid: \$ Paid: \$ g fees must accompany uses purchased.

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

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 877-303-2415