Out-Of-Network Claim Form

Most Vision Care plans allow members the choice to visit an in-network or out-of-network vision care provider. You only need to complete this form if you are visiting a provider that is not a participating provider in the network. Not all plans have out-of-network benefits, so please consult your member benefits information to ensure coverage of services and/or materials from non-participating providers.

If you choose an out-of-network provider, please complete the following steps prior to submitting the claim form. Any missing or incomplete information may result in delay of payment or the form being returned. Please complete and send this form to Vision Service within 1 year from the original date of service at the out-of-network provider's office.

1. When visiting an out-of-network provider, you are responsible for payment of services and/or materials at the time of service. Vision Service will reimburse you for authorized services according to your plan design.
2. Please complete all sections of this form to ensure proper benefit allocation. Plan information may be found on your benefit ID Card, or via your human resources department.
3. Vision Service will only accept **itemized receipts** that indicate the services provided and the amount charged for each service. The services must be paid in full in order to receive benefits. Handwritten receipts must be on the provider's letterhead. Attach itemized paid receipts from your provider to the claim form. If the paid receipt is not in US dollars, please identify the currency in which the receipt was paid.
4. Please include a copy of your Explanation of Benefits if submitting for a Secondary Insurance Benefit.
5. If the reimbursement is to be sent to someone other than the primary subscriber, a copy of a cancelled check or credit card receipt (in addition to the paid itemized receipt) must be included. A copy of a receipt showing payment in cash is also acceptable.
   By signing below, you are representing that you are legally divorced or separated and the patient is entitled to the reimbursement. If it is later determined that the patient was not entitled to the reimbursement, you agree to refund Vision Service in full.

Please indicate to whom the reimbursement should be sent: (Circle One) **Subscriber** **Patient**

6. Sign the claim form where indicated.

Date of Service: ___/___/_____

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birth Date: _____

Plan Information:

Subscriber Name

Last: _____ First: _____ MI: _____

Plan Name: _____

Subscriber ID: _____

Request For Reimbursement –Please Enter Amount Charged. Remember to include itemized paid receipts:			
Exam: $_____	Frames: $_____	Lenses: $_____	Contact Lenses – (includes fit and follow-up, please submit $_____ all contact related charges at the same time)
If lenses were purchased, please circle type: Single Bifocal Trifocal Progressive			

I hereby understand that without prior authorization from Vision Service Department for services rendered, I may be denied reimbursement for submitted vision care services for which I am not eligible. I hereby authorize any insurance company, organization employer, ophthalmologist, optometrist, and optician to release any information with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct.

Member/Guardian/Patient Signature (not a minor) _____ Date: _____

To Fax: 866-293-7373 To Email Form and Receipts: oonclaims@eyemedvisioncare.com

To Mail: **Vision Care Service Department**
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111