

Claim Form Instructions

Most plans allow members the choice to visit an in-network or out-of-network vision care provider, check your plan and see if this applies to you. You only need to complete this form if you are visiting a provider that is not a participating provider in the EyeMed 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 to EyeMed. Any missing or incomplete information may result in delay of payment or the form being returned. Please complete and send this form to EyeMed within the period of time specified by your plan. Refer to your SPD for specific details.

1. When visiting an out-of-network provider, you are responsible for payment of services and/or materials at the time of service. EyeMed 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 your SPD.
3. EyeMed will only accept **itemized paid 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. Sign the claim form below.

Return the completed form and your itemized paid receipts to:



EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Please allow at least 14 calendar days to process your claims once received by EyeMed. Your claim will be processed in the order it is received. A check and/or explanation of benefits will be mailed within seven (7) calendar days of the date your claim is processed.

Inquiries regarding your submitted claim should be made to the Customer Service number printed on the back of your benefit identification card.

Patient Information (Required)			
Last Name			
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Member ID #		Relationship to the Subscriber	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	

Subscriber Information (Required)			
Last Name			
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Birth Date (MM/DD/YYYY)		Telephone Number	
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Vision Plan Name		Vision Plan ID #	Subscriber ID #
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Date of Service (Required) (MM/DD/YYYY)
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Request For Reimbursement –Please Enter Amount Charged. Remember to include itemized paid receipts:			
Exam \$ _____	Frame \$ _____	Lenses \$ _____	Contact Lenses - (please submit all contact related charges at the same time) \$ _____
If lenses were purchased, please check type: <input type="checkbox"/> Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Progressive			

I hereby understand that 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: _____

