UnitedHealthcare®

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) ◯ Self ◯ 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

❍ **Eye / Vision Exam** **Paid: $**

Complete below for glasses OR...		Complete below for contacts	
Glasses		**Contacts**	
❍ Frames	Paid: $	❍ Contact Fitting / Exam	Paid: $
Glasses Lens Type (Check only one)		❍ Contact Lenses	Paid: $
◯ Single-vision lenses	Paid: $	Note: Contact fitting fees must accompany contact lenses purchased.	
◯ Bi-focal lenses	Paid: $		
◯ Tri-focal lenses	Paid: $	If service(s) received from an in-network provider, please include provider's National Provider Identification Number (NPI):	
◯ 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