EyeMed
The Eye Care Plan of America

Out Of Network Claim Form

Most EyeMed plans allow members to select the provider of their choice, in or out of the network. EyeMed has designed benefit plans to deliver the quality care, matched with comprehensive benefits, at the most affordable cost, through our in-network services. Members also have the flexibility to visit an out-of-network provider, with a reduction in benefits. Please consult your member benefits information to ensure coverage of non-participating provider services.

If you choose to go to an Out of Network provider, please complete the following steps prior to submitting your Out of Network claim form. Any missing or incomplete information may result in a delay in receiving payment or be returned to you.

1. When you choose a non-participating provider to receive vision care services, you are responsible for payment of vision care services at the time of service. EyeMed Vision Care will reimburse you for authorized services according to your plan design. Please consult your plan design for the listing of qualified services and their reimbursement amounts.
2. Complete ALL Sections of the form to ensure proper benefit allocation.
3. Complete the Plan Information Portion of your claim form. This information can be found on your benefit card or by contacting your Human Resources Department. You may substitute a photocopy of your benefit card.
4. Complete the Request for Reimbursement section. EyeMed will only accept itemized **paid** receipts that indicate the services provided and the amount charged for each service. Handwritten receipts must be on provider letterhead.
5. Sign the claim form.
6. 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.

DATE OF SERVICE _____ – _____ – _____

Claim Number/Authorization _____

PATIENT INFORMATION

NAME _____
(Last) (First) (MI)

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ - _____

Daytime Phone _____ DOB _____ – _____ – _____

PLAN INFORMATION

SUBSCRIBER NAME _____ _____ _____ DOB _____ – _____ – _____
(Last) (First) (MI)

PLAN NAME _____

Subscriber ID _____

REQUEST FOR REIMBURSEMENT

	EXAM	CONTACTS Includes Fit/Followup	LENS	FRAMES
AMOUNT CHARGED FOR SERVICES **(Remember to include itemized receipts)**	$_____	$_____	$_____	$_____

Type of Lens Single Bifocal Trifocal Progressive
(Please circle lens type purchased)

I hereby understand that without prior authorization from EyeMed Vision Care LLC for services rendered, I may not be reimbursed for submitted vision services for which I am ineligible. 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 / PATIENT SIGNATURE (Not a Minor) _____ DATE _____

Please mail the claim to:

EyeMed Vision Care
Attn OON CLAIMS
P.O. Box 498488
Cincinnati, OH 45249-8488

To Fax Information: **(866) 293-7373**
If the fax transmission is illegible, it will be returned to the sender via the same fax number.

To Email Form and receipts to
OONCLAIMS@eyemedvisioncare.com