UnitedHealthcare Vision®

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 (SSN)

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: $	
❍ 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