Out of Network
Vision Services Claim Form

Claim Form Instructions

Most EyeMed 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 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 one (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. 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 via your human resources department.
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.

EyeMed VISION CARE®

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Patient Information (**Required**)			
Last Name			
First Name			Middle Initial
Street Address	City	State	Zip Code
Birth Date (*MM/DD/YYYY*)	Telephone Number		
Member ID #	Relationship to the Subscriber Self ☐ Spouse ☐ Child ☐ Other ☐		

Subscriber Information (**Required**)			
Last Name			
First Name			Middle Initial
Street Address	City	State	Zip Code
Birth Date (*MM/DD/YYYY*)	Telephone Number		
Vision Plan Name	Vision Plan ID #	Subscriber ID #	

Date of Service (**Required**) (*MM/DD/YYYY*)

Request For Reimbursement –Please Enter Amount Charged. Remember to include itemized paid receipts:			
Exam $_____	Frame $_____	Lenses $_____	Contacts Lenses - (please submit all contact related charges at the same time) $_____
If lenses were purchased, please check type: ☐ Single ☐ Bifocal ☐ Trifocal ☐ Progressive			

I hereby understand that without prior authorization from EyeMed Vision Care LLC 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: _____

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