UNION EYE CARE

REIMBURSEMENT - VISION CLAIM FORM

This form is required for reimbursement if you go out of the network. Attach originals of all bills and make copies for your records. Be sure to enter the employee's name and ID No. or SSN along with the PLAN NAME or No. in the Employer/Group box. Please submit to the location listed on the back of the form.

THIS SECTION TO BE COMPLETED BY EMPLOYEE AND / OR PATIENT.... PLEASE PRINT.

Employee's Name (Last, First, Middle)	Employee SSN / ID No. - -	Employer / Group 325.00	Employee's Birthdate / /
Employee's Home Address	**City,**	**State,**	**ZipCode**

Patient's Name (Last, First, Middles)	Relationship to employee (spouse, child)	Sex M ☐ F ☐	Patient Birthdate / /	If Patient is a Dependent Child Over Age 18: Full Time Student? Yes ☐ No ☐ Disabled? Yes ☐ No ☐

Is Patient Covered By Another Vision Plan? Yes ☐ No ☐ **If yes, complete the following:** **Vision Plan Name** **Carrier Name and Address**

Are Other Family Members Employed? Yes ☐ No ☐ **Name** **Social Security No.** - -

Spouse's Birthdate / / **If yes furnish name and address of employer**

I hereby authorize any insurance company, organization, employer, Ophthalmologist, Optometrist or Optician to release any information with respect to this claim. Further, I agree to reimburse Union Eye Care Center, Inc. for any overpayment of benefits on this claim. In lieu of reimbursement, such overpayment may be deducted from future Vision Coverage benefits payable to me. I understand that any benefits payable for services will be paid to the Member.

Signature of Employee _____ Also, Signature of Dependent (If patient and not a minor) _____ Date _____

IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS YOU KNOW ARE FALSE OR TO LEAVE FACTS OUT YOU KNOW ARE IMPORTANT.

THIS SECTION TO BE COMPLETED BY PROVIDER OF PROFESSIONAL SERVICES .... PLEASE PRINT.

Date of Exam: / / Diagnosis :

Initial prescription Yes ☐ No ☐ *Refraction* Yes ☐ No ☐ *Contact Lens* Yes ☐ No ☐

If contact Lenses were prescribed. *Tonometry* Yes ☐ No ☐ *Cataract Surgery* Yes ☐ No ☐

Please indicate if: Cosmetic ☐ *Medicaly Necessary* ☐

Could visual acuity be corrected to 20/70 in the better eye by use of conventional lenses? Yes ☐ *No* ☐

TO OPHTHALMOLIGIST ONLY: Was the patient referred to you for an examination of an unresolved Medical or Pathological problem by an Optometrist who performed a vision examination within the last 60 days? Yes ☐ No ☐

AMOUNT PAID BY EMPLOYEE $ **EXAMINATION CHARGE $**

Type of Provider: Participating ☐ Non-Participating ☐

Name of provider who performed the service Phone No. ( ) -

Address City, State, Zip Code

Signature _____ Degree/Title _____ Date _____

SSN - -

Employer I.D. No. -

Must be furnished under authority of law.

THIS SECTION TO BE COMPLETED BY PROVIDER OF MATERIALS.... PLEASE PRINT.

Date Lenses Ordered / /

☐Single Vision ☐Plastic ☐Glass ☐Bifocal ☐Pair ☐1/2 Pa ☐Trifocal ☐Seg Style ☐Width ☐Lenticular ☐Executive ☐Panoptic ☐Progressive ☐Flattop ☐Flattop 28/35 ☐Round

	Sphere	Cylinder	Axis	Prism	Add	Miscellaneous
OD						
OS						

CONTACT LENSES	CHARGES
Hard	
Soft	
Gas Permeable	
Disposable - No of Pairs	
Other (please specify)	
Taxes	
SUBTOTAL	$

FRAMES

Date Frames Ordered

Frame Manufacturer

Frame Name

Type:Zyl Metal Rimless Combination

SUBTOTAL $

SPECTACLE LENSES	CHARGES
Oversized	
Sunglasses	
Tint #	
Photosensitive	
Gradient Tint	
Scratch Resistant	
UV Coating	
POLYCARB	
Other (specify)	
Taxes	
SUBTOTAL	$

TOTAL AMOUNT PAID BY EMPLOYEE $ **TOTAL CHARGE FOR LENSES AND FRAME (including taxes) $**

Type of Provider : Participating ☐ Non-participating ☐

Name of provider who performed the service Phone No. ( ) -

Address City, State, Zip Code

Signature _____ Degree/Title _____ Date _____

SSN - -

Employer I.D. No. -

Must be furnished under authority of law.

This form is only necessary if you intend to go out-of-network.

Please be sure to enter the PLAN NAME / NO.,

in the space provided in the Employee's Section. Enter all patient information.

For reimbursement you must attach and submit originals of all bills.

Please make copies for your records.

Mail this form and all attachments to:

VISION CARE ADMINISTRATOR
UNION EYE CARE
4750 BEIDLER ROAD
WILLOUGHBY, OHIO 44094

PHONE: 1 (800) 443-9699 1 (216) 986-9700

Extensions 17 & 19

FAX: 1 (216) 986-1996