OUT-OF-NETWORK VISION SERVICES CLAIM FORM

Claim Form Instructions

To request reimbursement of claims, check the appropriate box and follow the instructions listed below:

☐ **Coordination of Benefits (COB)** – complete, sign form and include the Explanation of Benefits (EOB) from other plan

☐ **Out-of-Network Provider** – complete, sign form and include your itemized receipts

☐ **LASIK Surgery** – complete, sign and include your itemized receipt. If you are an employee enrolled as a dependent, please call 1-833-279-4355 to ensure eligibility prior to submitting this form.

Mail the form and EOB or required receipt(s) to:

First American Administrators, Inc.
Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111

Patient Last Name† | **Patient First Name†** | **MI**

Birth Date (MM/DD/YYYY)† | **Street Address†**

City† | **State†** | **Zip Code†**

Patient Member ID # | **Relationship to Subscriber†**

Self ◯ Dependent ◯

†Required

Subscriber Last Name†

Subscriber First Name†

MI

Birth Date (MM/DD/YYYY)†

Street Address†

City†

State†

Zip Code†

Vision Plan Name

Date of Service† (MM/DD/YYYY)

Vision Plan Group #

Subscriber Member ID #

Doctor or Store where patient received services

Provider's Name†

Provider's NPI

Provider Street Address†

City†

State†

Zip Code†

†Required

continued

Request for Reimbursement

Enter Amount Charged.† Remember to include itemized paid receipts.†

Service Type	Amount Charged	Lens Type	Please Check	Lens Options: (if purchased)	Amount Charged
Exam *92014*	$	Single *V2100*	☐	Anti-Reflective *V2750*	$
Refraction *92015*	$	Bifocal *V2200*	☐	Polycarbonate *V2784*	$
Frame *V2025*	$	Trifocal *V2300*	☐	Scratch *V2760*	$
Contact Lens *S0500*	$	Progressive *V2781*	☐	Tint *V2745*	$
Contact Lens Fitting *92310*	$	Prem Prog *V278126*	☐	UV *V2755*	$
Lenses	$	Other	$	Roll and Polish *V2702*	$
LASIK *S0800*	$				

Enter Total Amount Paid as shown on receipt, excluding sales tax† $

I certify that I have read the state fraud warning statements, which can be found by logging into Member Web and clicking the Out-of-network claim form tab. If I want a printed copy, I can contact the customer call center. I understand that I may be denied reimbursement if I am not eligible for out-of-network benefits or if I do not supply the requested information for the claim. I authorize any insurance company, organization employer, ophthalmologist, optometrist and optician to release any information with respect to this claim. I agree with all statements above and certify all of the information furnished on this form is true and correct.

Member/Guardian/Patient Signature (not a minor)† **Date†**

†Required