VISION OUT-OF-NETWORK CLAIM FORM

Claim submissions made easy

WENT OUT-OF-NETWORK? NO PROBLEM, LET'S WALK THROUGH IT

If you saw an out-of-network eye doctor and you have out-of-network benefits, your next step is to send us your completed claim form. You can now submit your form online or by mail:

1. **Online.** Click below to complete an electronic claim form. Go green and get paid faster.

— or —

2. **By mail.** Complete and return the following paperwork.

Access form

For complete terms and conditions, review the claim form.

STAY IN-NETWORK AND SAVE ON YOUR NEXT VISIT*

CHOOSE AN EYE DOC

With thousands of providers across the nation, you can see who you want to see, when and where you want to see them. Whether it's an independent eye doctor, popular retailer or even online, you have options.

Easily find an eye doctor on eyemed.com or on the EyeMed Members App. Search by location, store hours and more – and then schedule your appointment.**

WATCH IT ADD UP

Members who combine an eye exam and new glasses save an average of 72% off retail prices.††

NEVER PAY STICKER PRICE

Pocket discounts like†:

- 40% off additional pairs
- 20% off non-prescription sunglasses
- Up to 20% off anything above your frame allowance

FORM-FREE

When you stay in-network, it's easy to get an eye exam and get on with your day. No paperwork. No hassles.

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) now.

INDEPENDENT PROVIDER NETWORK + LensCrafters PEARLE VISION OPTICAL sears OPTICAL

**Vision care services frequency may vary. Check your benefits to verify your frequency of services type. **At select in-network providers. †Discounts available at participating in-network providers. Discounts and benefits may vary. Check your benefits. ††Savings comparison of EyeMed versus care without vision benefits.*

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OUT OF NETWORK
VISION SERVICES CLAIM FORM

Administered By First American Administrators

All Patient and Subscriber Information is required for Claims Processing

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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 First American Administrators. Any missing or incomplete information may result in delay of payment or the form being returned. Please complete and send this form to First American Administrators within fifteen (15) months 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. First American Administrators 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. First American Administrators will only accept **itemized paid receipts** that indicate the services provided and the amount charged for each service. The patient name and date of service must be included on the receipt. 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. Sign the claim form below

Return the completed form and your itemized paid receipts to:

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

Please allow up to 30 days to process your claims once received by First American Administrators. 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.

Fraud Notice Statement: *Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.*

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Patient Last Name **(Required)**			
Patient First Name **(Required)**	MI	Birth Date (*MM/DD/YYYY*)	
Street Address	City	State	Zip Code
Patient Member ID:	Relationship to the Subscriber : ☐ Self ☐ Dependent		
Doctor or Store Name where you received service (Required) :			
Subscriber Last Name **(Required)**			
Subscriber First Name **(Required)**	MI	Birth Date (*MM/DD/YYYY*)	
Street Address	City	State	Zip Code
Vision Plan Name	Date of Service -**Required** (*MM/DD/YYYY*)		
Vision Plan Group #	Subscriber Member ID #		

REQUIRED- ***Request For Reimbursement –Enter Amount Charged. Remember to include itemized paid receipts:***

Service Type	Amount Charged	Lens Type:	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 & Polish *V2702*	$☐☐☐☐.☐☐

Required: Enter Total Amount Paid as shown on receipt, excluding sales tax $☐☐,☐☐☐.☐☐

Based from your home or office location, you have the right to obtain in-network level of benefits with an out-of-network provider when: (i) you cannot schedule a visit within two-weeks, (ii) you are unable to locate a participating provider within a 10-mile radius in an **urban-suburban** area, or (iii) you are unable to locate a participating provider within a 20-mile radius in a **rural area**. You must submit a claim form to EyeMed for reimbursement.

Caution, this option is not available when you choose to use an out-of-network provider due to (i) your preference, (ii) when your personal schedule does not permit you to schedule an appointment with an available provider in two-weeks, (iii) or you are outside of your home or office location. Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Check the boxes that apply. I acknowledge that I fit into one or more of the following criteria:

☐ I was unable to schedule a visit within two-weeks with a participating provider.

Please provide the participating provider's name, location and contact information in which you attempted to schedule an appointment:

Provider's name: _____ Location: _____ Telephone number: _____

☐ I was unable to locate a participating provider within a 10-mile radius in an **urban-suburban area**.

Please provide the zip code in which you were attempting to locate a provider: Zip code: _____

Or

☐ I was unable to locate a participating provider within a 20-mile radius in a **rural area**.

Please provide the zip code in which you were attempting to locate a provider: Zip code: _____

Should you fail to provide the requested information associated with the criteria you selected above, you agree that we can process your claim as an out-of-network claim.

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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Gen Pop *Out of Network*

Revision date 9/13/17

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STATE FRAUD WARNING STATEMENTS

For the states of AL, AZ, AR, CA, CO, DE, DC, FL, GA, KS, KY, LA, MD, ME, NC, NE, NJ, NM, OK, OR, PA, RI, TN, TX, VA, VT, WA and WV, please refer to the following fraud notices:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona, law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties**.**

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California, law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Oregon, Texas, Vermont: Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Kansas: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Nebraska: Any person, who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a material false or deceptive statement is guilty of insurance fraud.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

North Carolina: Any person with the intent to injure, defrauds, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.