OUT-OF-NETWORK VISION SERVICES CLAIM FORM

Claim Form Instructions

To request reimbursement, please complete and sign the itemized claim form. Return the completed form and your itemized paid receipts 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 ○

Doctor or Store Name where you received service†

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 #**

†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*	$

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

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. By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information furnished by me is true and correct.

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

†Required

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