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

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