



A UnitedHealthcare Company

Member Vision Claim Submission Form

IMPORTANT: We recommend all vision receipts be submitted online. You can do this by signing in to **umr.com**. Once you're signed in, select the **Claims** drop-down menu in the blue navigation bar. Under **Other tools**, select **Submit a claim**. Then, select **Submit an online claim**.

To be considered a valid claim, submit your receipt or itemized statement along with this completed claim form containing the required information. Please refer to filing instructions included for the supporting documentation required for claim submission.

Sufficient documentation is required for the claim to be processed.

Personal information

Name of employer _____	Plan group number _____					
Name of employee _____	Member ID _____					
Patient's name _____	Date of birth <table><tr><td>MM</td><td>/</td><td>DD</td><td>/</td><td>YYYY</td></tr></table>	MM	/	DD	/	YYYY
MM	/	DD	/	YYYY		
Employee phone number and/or email address _____						
Issue payment to ☐ Member ☐ Provider	Date of purchase/service: <table><tr><td>MM</td><td>/</td><td>DD</td><td>/</td><td>YYYY</td></tr></table>	MM	/	DD	/	YYYY
MM	/	DD	/	YYYY		
Facility name _____	Provider					
Provider name _____	9-digit tax ID#* _____					
Provider address _____	*Required field – See filing instructions for online TIN or contact your provider to obtain information.					

Check all that apply. List dollars paid in front of each checked item. Make sure the total paid matches the attached receipt. Please note: All service types may not be covered under your plan. When entering the total amount paid, subtract any discounts, shipping and handling/delivery fees or sales tax.

Reason for vision exam (check one):	☐ Routine annual vision exam ☐ Medical vision exam (i.e., glaucoma, diabetic)
	Provide reason for visit: _____

Charges incurred:

☐ Vision exam, paid \$ _____	☐ Refraction, paid \$ _____								
Lenses:	<table><tr><td>☐ Single lenses, paid \$ _____</td><td>☐ Progressive lenses, paid \$ _____</td></tr><tr><td>☐ Bifocal Lenses, paid \$ _____</td><td>☐ Lens coating, paid \$ _____</td></tr><tr><td>☐ Trifocal lenses, paid \$ _____</td><td>☐ Other, paid \$ _____</td></tr><tr><td>☐ Lenticular lenses, paid \$ _____</td><td>Description: _____</td></tr></table>	☐ Single lenses, paid \$ _____	☐ Progressive lenses, paid \$ _____	☐ Bifocal Lenses, paid \$ _____	☐ Lens coating, paid \$ _____	☐ Trifocal lenses, paid \$ _____	☐ Other, paid \$ _____	☐ Lenticular lenses, paid \$ _____	Description: _____
☐ Single lenses, paid \$ _____	☐ Progressive lenses, paid \$ _____								
☐ Bifocal Lenses, paid \$ _____	☐ Lens coating, paid \$ _____								
☐ Trifocal lenses, paid \$ _____	☐ Other, paid \$ _____								
☐ Lenticular lenses, paid \$ _____	Description: _____								
Contact lenses:	<table><tr><td>☐ Lens fitting, paid \$ _____</td><td>☐ Contacts, paid \$ _____</td></tr></table>	☐ Lens fitting, paid \$ _____	☐ Contacts, paid \$ _____						
☐ Lens fitting, paid \$ _____	☐ Contacts, paid \$ _____								
Glasses:	<table><tr><td>☐ Frames, paid \$ _____</td><td></td></tr><tr><td>☐ Safety glasses, paid \$ _____</td><td></td></tr></table>	☐ Frames, paid \$ _____		☐ Safety glasses, paid \$ _____					
☐ Frames, paid \$ _____									
☐ Safety glasses, paid \$ _____									

Total amount paid: \$ _____

(Continued)

Please describe services rendered if you are unable to match to categories on previous page:

Filing instructions:

You may submit your claim to UMR by one of the following methods

Fax:

855-444-2896

Mail:

**Send to the address
on your UMR ID card**

- 1** Use this form to file a claim for any eligible vision charges. Please print clearly with black ink completing all required fields.
- 2** Attach your itemized statement (or fully legible copy of receipts) to the back of this form. Keep a copy for your records.
 - a. Please indicate the member ID number on any attachments.
 - b. Staple any attachments to the back of the claim form, not the front.
- 3** Please use a separate claim form for each family member.
- 4** Use your UMRs ID card for:
 - a. Name of employer
 - b. Plan group number
 - c. Name of member (as it appears on the ID card)
- 5** Patient name and date of birth must match UMR's eligibility file.
 - a. For example, if your name is Eugene Smith on your employer enrollment form, claim must state Eugene, not Gene.
- 6** Name, address, and Tax ID number (TIN) of the provider of service is required. If the provider's Tax ID number (9 digit number) is not on your copy of the itemized statement or receipt, you can contact their office to obtain it.
- 7** Balance due statements are not valid statements or receipts. See above for information needed to constitute a valid claim.

Below are some confirmed online Provider TINs. Please use only when appropriate:

Facility	TIN
1-800 Contacts	870571643
Frames Direct	760459412
Glasses USA	981385007
Warby Parker	800423634
Zenni	454185057
Contacts Direct	311339854
EyeBuyDirect	203678882