Humana.

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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Network Access Exceptions

We work hard to make sure that you have access to thousands of eye doctors across the nation. Whether it's due to location or provider availability, you may need to go out-of-network to receive care.

If this applies to you, please complete the following form. If not, please skip this section.

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.

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OUT-OF-NETWORK VISION SERVICES CLAIM FORM

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

Provider Telephone Number (000-000-0000)

Provider Street Address

City

State

Zip Code

☐ 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.

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