



# Vision Services Claim Form

*Out-of-Network/Reimbursement*

## *Claim form instructions*

Most Health Net Vision plans allow members to select the provider of their choice, in- or out-of-network. Health Net Vision has designed benefit plans that deliver quality care matched with comprehensive benefits at the most affordable cost, through our in-network services. Members also have the flexibility to visit an out-of-network provider, with a reduction in benefits. Please consult your member benefits information to ensure coverage of non-participating provider services. Health Net Vision plans are administered by EyeMed Vision Care Inc., LLC.

The Health Net Vision network includes many eye professionals in your area; before submitting an out-of-network reimbursement claim form for services, please consult with your eye care provider to confirm whether or not he/she participates on the Health Net Vision network. Please consult with the provider office regarding the submission of your vision claim.

If you choose an out-of-network provider, please complete the following steps prior to submitting the claim form to Health Net Vision. Any missing or incomplete information may result in a delay of payment or the form being returned. Please complete and send this form to Health Net Vision 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. Health Net Vision 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. Health Net Vision 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 U.S. 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:**

Health Net Vision  
Attn: OON Claims  
PO Box 8504  
Mason, OH 45040-7111  
Fax number: 1-866-293-7373  
Email address: [oonclaims@eyemedvisioncare.com](mailto:oonclaims@eyemedvisioncare.com)

**Please allow at least 14 calendar days to process your claims once received by Health Net Vision.** 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.

*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.*

All Patient and Subscriber Information is required for Claims Processing

<b>Patient Last Name (Required)</b>				
<b>Patient First Name (Required)</b>		<b>MI</b>	<b>Birth Date (MM/DD/YYYY)</b> - -	
<b>Street Address</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Patient Member ID:</b>		<b>Relationship to the Subscriber :</b> <input type="checkbox"/> Self <input type="checkbox"/> Dependent		
<b>Doctor or Store Name where you received service (Required) :</b>				
<b>Subscriber Last Name (Required)</b>				
<b>Subscriber First Name (Required)</b>		<b>MI</b>	<b>Birth Date (MM/DD/YYYY)</b> - -	
<b>Street Address</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Vision Plan Name</b>		<b>Date of Service -Required (MM/DD/YYYY)</b> - -		
<b>Vision Plan Group #</b>		<b>Subscriber Member ID #</b>		
<b>REQUIRED- Request For Reimbursement –Enter Amount Charged. Remember to include itemized paid receipts:</b>				
<b>Service Type</b>	<b>Amount Charged</b>	<b>Lens Type:</b>	<b>Lens Options: (if purchased)</b>	<b>Amount Charged</b>
<b>Exam</b> ■■■■■■■	\$	<input type="checkbox"/> <b>Single</b> ■■■■■■■	<b>Anti-Reflective</b> ■■■■■■■	\$
<b>Refraction</b> ■■■■■■■	\$	<input type="checkbox"/> <b>Bifocal</b> ■■■■■■■	<b>Polycarbonate</b> ■■■■■■■	\$
<b>Frame</b> ■■■■■■■	\$	<input type="checkbox"/> <b>Trifocal</b> ■■■■■■■	<b>Scratch</b> ■■■■■■■	\$
<b>Contact Lens</b> ■■■■■■■	\$	<input type="checkbox"/> <b>Progressive</b> ■■■■■■■	<b>Tint</b> ■■■■■■■	\$
<b>Contact Lens Fitting</b> ■■■■■■■	\$	<input type="checkbox"/> <b>Prem Prog</b> ■■■■■■■	<b>UV</b> ■■■■■■■	\$
<b>Lenses</b>	\$	<b>Other \$</b>	<b>Roll &amp; Polish</b> ■■■■■■■	\$
<b>Required: Enter Total Amount Paid as shown on receipt, excluding sales tax \$</b>				

*I hereby understand that without prior authorization from Health Net Vision 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:** \_\_\_\_\_



Revision date 4/2017

### *Fraud warning statements*

**FRAUD NOTICE:** For the states of AL, AZ, AR, CA, CO, DE, DC, FL, GA, IN, 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 Fraud Notice:** 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:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of 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, 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.

**Indiana:** 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.

**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.

*(continued)*

**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/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, defraud, 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.

**Texas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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