Opticare Plus Vision Out of Network Reimbursement Request

Insured Member Identification Number _____

Insured Member's Full Name _____

Insured Daytime Phone Number _____

Insured Address _____

Patient Name _____

Date of Service _____

Place of Service - Provider Name _____

Provider Phone Number _____

Provider Address _____

Itemized Price(s) Paid	
Examination	
Dilation	
Contact Fitting	
Lenses	
Scratch Coating	
UV Coating	
Coatings and Extras	
Frame	
Contact Lenses	

Please submit completed form & itemized receipt to:

Opticare Plus Vision
1901 West Parkway Blvd
Salt Lake City, UT 84119
Fax (801) 954-0054
Toll Free Fax (888) 547-4227

Questions or Comments :

service@opticareplus.com
(800) 363-0950
www.opticareplus.com

Policy and Procedures

Opticare Plus Vision will process your claim within 30 days from the date received. All information requested is required to process your claim completely. If information is missing, the claim will not be processed completely and may add time to the receipt of payment. Opticare Plus Vision will mail your check to the insured's mailing address listed on file. If the address may have changed recently, please contact the insured's Human Resource department to have them submit the address change to Opticare Plus Vision for updating.
Out of Network Provider must be a licensed Optician, Optometrist, or Ophthalmologist to qualify - No website/online purchases are covered. Full Allowance qualification is based on retail pricing. Please see Plan Outline.

OPV.OON.REQ