UnitedHealthcare Vision Claim Form

OUT OF NETWORK VISION REIMBURSEMENT REQUEST

TODAY'S DATE		DATE OF SERVICE	
EMPLOYEE NAME		EMPLOYEE'S UNIQUE IDENTIFICATION NUMBER OR SSN	
ADDRESS WHERE CHECK SHOULD BE MAILED (STREET ADDRESS OR P.O. BOX , CITY, STATE, ZIP CODE)			
CITY:	STATE:	ZIP:	
PATIENT'S NAME	PATIENT RELATIONSHIP TO EMPLOYEE	PATIENT'S DATE OF BIRTH	
EMPLOYEE / PATIENT SIGNATURE		DATE OF SIGNATURE	

To receive reimbursement from a non-network provider, mail your itemized receipts with this claim submission form. **Please note the following important information:**

- This reimbursement form is for UnitedHealthcare Vision members only
- The CITGO Vision Plan participant and/or eligible covered family members must be eligible for benefits to receive reimbursement.
- Check your eligibility and benefits at www.myuhcvision.com prior to making your purchase.
- If you have any questions on your vision coverage, please call the UnitedHealthcare Vision Customer Service Department at (800) 638-3120. Please have the employee's Social Security number ready.
- UniitedHealthcare Vision will reimburse you for eligible covered expenses according to the CITGO Vision Plan Provisions for the Out of Network benefit schedule.

UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
Fax: 1-248-733-6060