Victoria Independent School District

▪ 102 Profit Drive ▪ P. O. BOX 1759 ▪ Victoria, Texas 77902 | 361-788-9229 ▪ FAX 361-788-9252

Office of Human Resources – Employee Benefits

Humana
Specialty Benefits
Out-of-Network Vision Claim Form

Date of Service _____

Group Name Humana Vision Care Plan_____

Subscriber ID _____

Subscriber (Date of birth) _____

Patient Name _____

Patient (Date of birth) _____

Please provide the subscriber's current mailing address

_____
_____
_____

Please place and "X" in the box next to each service you received, and include the dollar amount you were charged for the service.

- ○ **Exam** $_____
- ○ **Filling of Contacts** $_____
- ○ **Contacts** $_____
- ○ **Single Vision Lenses** $_____
- ○ **Bifocal Lenses** $_____
- ○ **Trifocal/Progressive Lenses** $_____
- ○ **Frame** $_____

Please complete and sign this form. Copies of your itemized receipts must be included. If you need help in filling out this form, please contact Customer Care or (800) 865-3676.

I authorize the release of records to process this claim.

Signed_____ **Date**_____

Submit claims to:
Humana/Comp Benefits
Attn: Non-Panel Claims
P.O. Box 14282
Lexington, KY 40512-4282