



Eye Glasses/Contact Lens Reimbursement Form

- Please use this form for reimbursement of your routine or Post-Cataract Eyewear benefit.
- Reimbursement forms must be received no later than one year after the date you paid for the service.
- Please PRINT. For more information about completing the form, see the reverse side.

Member Information (for the specific member using this benefit):

Member ID #: Ex: 820000000-00	8										0	0
Member's Last Name:	First Name:				Middle Initial:				Date of Birth:			
Address:				City/State/Zip Code:				Phone Number:				
Name, address, phone number of service provider:												
Total number of receipts attached:								Place of Service:		11		
Are these eyeglasses for Post Cataract Surgery? (check YES or NO)				<input type="checkbox"/> YES (See reverse)				<input type="checkbox"/> NO				
Date of Purchase: (MM/DD/YYYY)		Type of Service (Circle all that applies):				Amount Paid:						
		Eye Glass Frames– V2020										
		Eye Glass Lenses – V2100										
		Contact Lenses – V2500										

Certification and Authorization: (this form must be signed below)

I authorize the release of any information to MVP Health Care about my eye glasses/contact lens utilization. I certify that the information provided in support of this submission is complete and accurate. It has not and will not be submitted for reimbursement under any other health plan coverage (such as a Flexible Spending Account).

Subscriber's signature

Date

Any person who knowingly files a reimbursement request containing any misrepresentation or any false, incomplete or misleading information is guilty of a criminal act punishable under law and may be subject to civil penalties.

Return to: MVP Health Care, Medicare Advantage Eye Glasses/Contact Lens, P.O. Box 2207, Schenectady, NY 12301. (See reverse for guidelines on completing this form.)

For MVP Internal Use Only:

PIN: DR EYEWEAR
Cataract Dx: V431

NPI: 1999999984
Routine Dx: V720

EIN: 199999998

How to Submit Your Eye Glasses/Contact Lens Reimbursement Request

In order to process your request promptly, please refer to the following guidelines to ensure that all necessary information is included.

1. This form may be used by MVP Medicare Advantage members when submitting a reimbursement request for your eyewear benefit. A separate form must be completed for each eligible member of your household.
2. The following items are not covered: safety glasses required by employers, non-prescription eyeglasses; non-prescription sunglasses and non-prescription contact lenses; extended-wear contact lenses, non-prescription sports-related protective eyewear, tinting of lenses.
3. Medicare allows one pair of prescription eyeglasses or contact lenses within 12 months after each cataract surgery. If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two pairs of eyeglasses after the second surgery.
4. All reimbursement forms must be received by MVP Health Care no later than one year after the date you paid for the service.
5. Attach the pre-printed, paid original receipt showing the type of service:
 - You must pay for the service before submitting a request for reimbursement.
 - For each item you are requesting, you must attach a copy of itemized bills, statements or receipts pre-printed or stamped or on company letterhead with the service provider's name and address.
 - Balance forward/prior balance statements are not acceptable.
 - Your claim form must include the following information:
 - Your name and MVP member ID number
 - The name and address of the provider
 - Are these eyeglasses for post-cataract surgery?
 - The type of service provided (circle all that applies)
 - The date of purchase
 - Your out-of pocket cost for the service
 - **Please note:** reimbursement requests that are not submitted according to these guidelines will be returned for you to correct and re-submit.
6. MVP Health Care reserves the right to refuse reimbursement if the service provider does not meet benefit and quality standards as determined by MVP Health Care.
7. Sign this form and return it to: MVP Health Care
Medicare Advantage Eye Glasses/Contact Lens
P.O. Box 2207
Schenectady, NY 12301
8. Please allow 4-6 weeks for reimbursement (as long as your request is complete and accurate).
9. Please visit our website at www.mvphealthcare.com for more information about your eyewear benefit.

MVP Health Care is dedicated to prompt and accurate reimbursements to our health plan participants. By following these instructions and filling out the reimbursement form completely, you will help us process your request in a satisfactory manner. Thank you!