Blue View Vision℠ Out of Network Claim Form

If you choose an out-of-network provider, please complete the following steps prior to submitting the claim form to Blue View Vision. Not all plans have out-of-network benefits, so please consult your member benefits information to ensure coverage of services and/or materials from out-of-network providers. Any missing or incomplete information may result in delay of payment or the form being returned. Please complete and send this form to Blue View Vision within one (1) year from the original date of service by an 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. Blue View Vision will reimburse you for authorized services according to your plan benefits. Check will be sent directly to a dependent if that dependent is over the age of 18.
   Please indicate to whom the reimbursement should be sent: (CHECK ONE) ☐ **Subscriber** ☐ **Patient**
2. Please complete all sections of this form to ensure proper benefit allocation.
3. Blue View Vision will only accept **itemized receipts** that indicate the services provided and the amount charged for each service. 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 US dollars, please identify the currency in which the receipt was paid.
4. Sign the claim form where indicated.

DATE OF SERVICE: __/__/_____

Patient Information:

FIRST NAME: _____ LAST NAME: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ BIRTH DATE: __/__/_____

Plan Information:

SUBSCRIBER NAME

FIRST NAME: _____ LAST NAME: _____ MI: _____

PLAN NAME: _____

SUBSCRIBER ID: _____

Request For Reimbursement – Please Enter Amount Charged. Remember to include itemized paid receipts.

Exam: $ 0.00 Frames: $ 0.00 Lenses: $ 0.00 Contact Lenses: $ 0.00

(includes fit and follow-up; please submit all contact related charges at the same time)

If lenses were purchased, please check type: ☐ Single ☐ Bifocal ☐ Trifocal ☐ Progressive

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I hereby understand that 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.

Signature of Member/Guardian/Patient (not a minor) _____ Date _____

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To Mail: **Blue View Vision**
Attn: Vision Claims
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