spectera®

Vision Plan Out-of-Network Claim Form

Please complete the employee and patient information

Today's Date	Date of Service
Primary Insured's Name	First 5 digits of the Primary Insured's Social Security Number OR 9-digit Member ID Number

Address where check should be mailed

Address

City	State	ZIP

Patient's Name	Patient's Relationship to Employee (check one) ❍Self ❍Dependent	Patient's Date of Birth

Please complete services and materials received. You must provide the costs paid. Costs paid must match submitted receipt(s).

Please Note: Receipts must be submitted together at the same time for services and materials purchased (even if purchased on different dates) to receive reimbursement. You will receive a one-time reimbursement based on your service frequency in your employer's vision care plan.

Exam

❍ **Eye / Vision Exam** **Paid: $**

Complete below for glasses **OR...**		**Complete below for contacts**	
Glasses		**Contacts**	
❍ Frames	Paid: $	❍ Contact Fitting / Exam	Paid: $
Glasses Lens Type (Check only one)		❍ Contact Lenses	Paid: $
❍ Single-vision lenses	Paid: $	Note: Contact fitting fees must accompany contact lenses purchased.	
❍ Bi-focal lenses	Paid: $		
❍ Tri-focal lenses	Paid: $	If service(s) received from an in-network provider, please include provider's National Provider Identification Number (NPI):	
❍ Lenticular lenses	Paid: $		

Employee Signature	**Date**

Please return this form with a copy of your paid, itemized receipt to:

Spectera
ATTN: Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
Fax: (248) 733-6060

Questions? You can call our Customer Service Department at 877-303-2415