



**Opticare Plus Vision Out of Network Reimbursement Request**

Insured Member Identification Number \_\_\_\_\_

Insured Member's Full Name \_\_\_\_\_

Insured Daytime Phone Number \_\_\_\_\_

Insured Address \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Service \_\_\_\_\_

Place of Service - Provider Name \_\_\_\_\_

Provider Phone Number \_\_\_\_\_

Provider Address \_\_\_\_\_

<b>Itemized Price(s) Paid</b>	<b>Examination</b>	_____
	<b>Dilation</b>	_____
	<b>Contact Fitting</b>	_____
	<b>Lenses</b>	_____
	<b>Scratch Coating</b>	_____
	<b>UV Coating</b>	_____
	<b>Coatings and Extras</b>	_____
	<b>Frame</b>	_____
	<b>Contact Lenses</b>	_____

**Please submit completed form & itemized receipt to:**

**Opticare Plus Vision  
 1901 West Parkway Blvd  
 Salt Lake City, UT 84119  
 Fax (801) 954-0054  
 Toll Free Fax (888) 547-4227**

Questions or Comments :

[service@opticareplus.com](mailto:service@opticareplus.com)  
 (800) 363-0950  
[www.opticareplus.com](http://www.opticareplus.com)

**Policy and Procedures**

Opticare Plus Vision will process your claim within 30 days from the date received. All information requested is required to process your claim completely. If information is missing, the claim will not be processed completely and may add time to the receipt of payment. Opticare Plus Vision will mail your check to the insured's mailing address listed on file. If the address may have changed recently, please contact the insured's Human Resource department to have them submit the address change to Opticare Plus Vision for updating.

*Out of Network Provider must be a licensed Optician, Optometrist, or Ophthalmologist to qualify - No website/online purchases are covered. Full Allowance qualification is based on retail pricing. Please see Plan Outline.*