Blue View Vision℠

Out of Network
Vision Services Claim Form

Claim Form Instructions

Most Blue View Vision Care plans allow members the choice to visit an in-network or out-of-network vision care provider. You only need to complete this form if you are visiting a provider that is not a participating provider in the Blue View Vision network. Not all plans have out-of-network benefits, so please consult your member benefits information to ensure coverage of services and/or materials from non-participating providers.

If you choose an out-of-network provider, please complete the following steps prior to submitting the claim form to Blue View Vision. 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 at the 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 design.
2. Please complete all sections of this form to ensure proper benefit allocation. Plan information may be found on your benefit ID Card or via your human resources department.
3. Blue View Vision will only accept **itemized paid 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 below.

Return the completed form and your itemized paid receipts to:

Mail To:

Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Fax To: **866-293-7373**

Email To: oonclaims@eyewearspecialoffers.com

Please allow at least 14 calendar days to process your claims once received by Blue View Vision. Your claim will be processed in the order it is received. A check and/or explanation of benefits will be mailed within seven (7) calendar days of the date your claim is processed.

Blue View Vision reimbursement checks are issued by EyeMed Vision Care. Look for an EyeMed envelope in the mail.

Inquiries regarding your submitted claim should be made to the Customer Service number printed on the back of your benefit identification card.

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Patient Information (**Required**)			
Last Name			
First Name			Middle Initial
Street Address	City	State	Zip Code
Birth Date (*MM/DD/YYYY*)	Telephone Number		
Member ID #	Relationship to the Subscriber Self ☐ Spouse ☐ Child ☐ Other ☐		

Subscriber Information (**Required**)			
Last Name			
First Name			Middle Initial
Street Address	City	State	Zip Code
Birth Date (*MM/DD/YYYY*)	Telephone Number		
Vision Plan Name	Vision Plan ID #	Subscriber ID #	

Date of Service (**Required**) (*MM/DD/YYYY*)	***Blue View Vision reimbursement checks are issued by EyeMed Vision Care. Look for an EyeMed envelope in the mail.***

Request For Reimbursement –Please Enter Amount Charged. Remember to include itemized paid receipts:			
Exam $_____	Frame $_____	Lenses $_____	Contact Lenses - (please submit all contact related charges at the same time) $_____
If lenses were purchased, please check type: ☐ Single ☐ Bifocal ☐ Trifocal ☐ Progressive			

I hereby understand 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.

Confidential When Complete

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

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