OUT-OF-NETWORK VISION SERVICES CLAIM FORM

Claim submissions made easy

WENT OUT-OF-NETWORK? NO PROBLEM, LET'S WALK THROUGH IT

If you saw an out-of-network eye doctor and you have out-of-network benefits, your next step is to send us your completed claim form. You can now submit your form online or by mail:

Online

Click below to complete an electronic claim form. Go green and get paid faster.

–OR–

By mail

Complete and return the following paperwork.

Access Form ▶

Or use the following link:
http://bit.ly/40dnm7R

If you will be using electronic assistive devices to complete the form, please use the online form.

State Fraud Warning Statements

General Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

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Claim Form Instructions

To request reimbursement, please complete and sign the itemized claim form. Return the completed form and your itemized paid receipts to:

First American Administrators, Inc.
Attn: OON Claims, PO Box 8504, Mason, OH 45040-7111

Patient Last Name† | Patient First Name† | MI

Birth Date (MM/DD/YYYY)† | Street Address†

City† | State† | Zip Code†

BCBSMA Member ID # | Relationship to Subscriber†

Self ◯ Dependent ◯

†Required

continued

Subscriber Last Name†

Subscriber First Name†

MI

Birth Date (MM/DD/YYYY)†

Street Address†

City†

State†

Zip Code†

Date of Service† (MM/DD/YYYY)

Doctor or Store where patient received services

Provider's Name†

Provider's NPI

Provider Street Address†

City†

State†

Zip Code†

†Required

continued

Request for Reimbursement

Enter Amount Charged.† Remember to include itemized paid receipts.†

Service Type	Amount Charged	Lens Type	Please Check	Lens Options: (if purchased)	Amount Charged
Exam *92014*	$	Single *V2100*	☐	Anti-Reflective *V2750*	$
Refraction *92015*	$	Bifocal *V2200*	☐	Polycarbonate *V2784*	$
Frame *V2025*	$	Trifocal *V2300*	☐	Scratch *V2760*	$
Contact Lens *S0500*	$	Progressive *V2781*	☐	Tint *V2745*	$
Contact Lens Fitting *92310*	$	Prem Prog *V278126*	☐	UV *V2755*	$
Lenses	$	Other	$	Roll and Polish *V2702*	$

Enter Total Amount Paid as shown on receipt, excluding sales tax† $

I certify that I have read the state fraud warnings. If I want a printed copy, I can contact the customer call center. I understand that I may be denied reimbursement if I am not eligible for out-of-network benefits or if I do not supply the requested information for the claim. I authorize any insurance company, organization employer, ophthalmologist, optometrist and optician to release any information with respect to this claim. I agree with all statements above and certify all of the information furnished on this form is true and correct.

Member/Guardian/Patient Signature (not a minor)† **Date**

†Required

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