STATE OF TEXAS VISION

EyeMed

Out-of-Network Claim Reimbursement Request Form

Use this form if you receive vision services from an out-of-network provider. To request reimbursement, please complete and sign the itemized claim form. Return the completed form and your itemized paid receipts to:

EyeMed/ 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†

Patient 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†

Vision Plan Group Name

State of Texas Vision

Date of Service† (MM/DD/YYYY)

Vision Plan Group #

1050072

Subscriber Member ID #

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
Exam *92014*	$
Refraction *92015*	$
Frame *V2025*	$
Contact Lens *S0500*	$
Contact Lens Fitting *92310*	$
Lenses	$

Lens Type	Please Check
Single *V2100*	☐
Bifocal *V2200*	☐
Trifocal *V2300*	☐
Progressive *V2781*	☐
Prem Prog *V278126*	☐
Other	$

Lens Options: (if purchased)	Amount Charged
Anti-Reflective *V2750*	$
Polycarbonate *V2784*	$
Scratch *V2760*	$
Tint *V2745*	$
UV *V2755*	$
Roll and Polish *V2702*	$

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

I authorize any insurance company, organization employer, ophthalmologist, optometrist, and optician to release any information with respect to this claim. I acknowledge any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

†Required

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