Out-of-Network Claims if you have Out-of-Network Benefits

Use this form if you receive vision services from an out-of-network eye doctor and you have out-of-network benefits. If your plan does not include out-of-network benefits, please see the Network Exceptions form, claim form 2, for separate processing instructions.

If you are a Medicare member, you may use this form or just submit a written request with all information that would be on the form.

To request reimbursement, please complete page 2 and page 3 and sign the itemized claim form. You do not need to complete the Patient Information section below.:

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 Name

Date of Service† (MM/DD/YYYY)

Vision Plan Group #

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	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

PDF-2005-M-390