



Please check your plan documents carefully before filling out this form. You may use this form only if your Summary of Benefits shows you have out-of-network vision coverage and your out-of-network provider has not already accepted payment directly from us. This form may not be used for coinsurance or copays. **Note:** if you are a Medicare member, and your provider has “opted out” of Medicare, services performed by that provider may not qualify for member payment.

## Instructions

1. Please complete one form per member per provider.
2. Use this form for vision claims only.
3. Bring this form with you to your appointment. You will need your provider to help complete the provider section on this form. Please refer to the Help Sheet/FAQ for more information.
4. To request reimbursement, please submit the following required documents to the address listed at the bottom of this form:
  - a. This completed reimbursement form, signed by the member or member authorized representative
  - b. Proof of services rendered including the **CPT code(s)** and **diagnosis codes(s)** reported on the date you received care – your provider may supply you with a completed CMS 1500 insurance claim form (“Physician or Supplier Information” section) with all of this information.
  - c. Proof of your payment for services requested for reimbursement (copy of an itemized bill or superbill with provider’s letterhead and paid receipt).
5. Reimbursement will be sent to the address we have on file for you. Any missing information will result in denial or rejection of the request.
6. Keep a copy of all receipts and documents for your records.

### Please Check Your Applicable Plan:

Wellcare	Marketplace	Other
Ohio	Arkansas (Premier)	UPMC Pennsylvania
South Carolina	Indiana (Ambetter Solutions)	Texas Community First
	Missouri (Ambetter Solutions)	
	New Hampshire (Premier)	
	Oklahoma	

Please submit this form and all documentation to:  
 Envolve Benefit Options • Claims Department-Member Reimbursement • P.O. Box 7548 • Rocky Mount, NC 27804

# MEMBER REIMBURSEMENT VISION CLAIM FORM



## Member Information

Please fill out completely – missing information will cause denial.

Member ID#:	Last Name:	First Name:	Middle Initial:	Date of Birth:
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Member Mailing Address (include City, State, and ZIP):

Telephone Number:	Does Member have other insurance?  Yes      No	Did other insurance make a payment? (If yes, include plan's EOB)  Yes      No	Primary Subscriber on Member Policy Self      Spouse Dependent
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## Provider/Claim Information

All information in this section is required. Your provider will need to assist you in completing this section.

Provider Name:	Telephone Number:	Rendering Provider NPI #:	Office Tax ID #:
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Provider Office Street Address (include City, State, and ZIP):

Diagnosis Code(s) (if blank, we will assume routine eye exam):

Service Type	Amount Charged	Lens Type	Choose One	Lens Options (if purchased)	Amount Charged
Exam <b>92014</b>	\$	Single <b>V2100</b>		Roll and Polish <b>V2702</b>	\$
Refraction <b>92015</b>	\$	Bifocal <b>V2200</b>		Tint <b>V2745</b>	\$
Frame <b>V2020/V2025</b>	\$	Trifocal <b>V2300</b>		Anti-reflective <b>V2750</b>	\$
Contact Lens <b>S0500</b>	\$	Fitting Fee <b>92340</b>	\$	Scratch Resistant <b>V2760</b>	\$
Contact Lens Fitting <b>92310</b>	\$	Fitting Fee <b>92341</b>	\$	Polycarbonate <b>V2784</b>	\$
Other	\$			Total Amount Paid:	\$

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be canceled, and I may be subject to criminal and/or civil penalties for false healthcare claims. I understand that reimbursement payment will be sent to the address on file and will contain information about the service(s) (e.g., provider name, date, description of service). I also understand Envolve Benefit Options may request any additional information it deems necessary to verify services were received and payment was made prior to processing this request.

Printed Member Name	Member/Representative Signature	Date
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# MEMBER REIMBURSEMENT VISION CLAIM FORM - HELP SHEET/FAQs



Question	Answer
What is this form used for?	This form is used to request member reimbursement of covered vision services for members with out-of-network benefit coverage. Members with out-of-network coverage will be considered for reimbursement only when services are performed by a provider who is not in our network. Coinsurance, deductibles, and/or copayments will still apply; non-covered services will not be reimbursed. <b>Submission of this form is not a guarantee of payment.</b>
What is my responsibility?	If you receive care from an out-of-network provider, you may only receive reimbursement up to the allowed amount for covered services according to your plan benefits. Member coinsurance, deductibles, and/or copayments will still apply. You may be also responsible for any unpaid charges billed by your provider.
What happens next?	After processing your claim, you will receive an Explanation of Benefits (EOB). The EOB explains your payment, coinsurance, and any charges you may owe the provider. Please keep your EOB in case you need it in the future.
Who should I call if I need help completing this form?	Your provider should be able to assist you. Call the Member Services number on your health plan member ID card if you have further questions.

Field Name	Description
Member ID#	Subscriber ID found on the front of your health plan member ID card
Name	Last/First name, Middle Initial of member who received services
Date of Birth	Month (2 digits), Day (2 digits), Year (4 digits) – MM/DD/YYYY
Address, Telephone	Include area code with telephone number.
Other Insurance Coverage	Choose Yes or No.
Other Insurance Payment	Choose Yes, No, or N/A. Primary insurance EOB is required if applicable.
Provider Name, Address, Telephone Number, NPI #, Federal Tax ID #	Use the address of the location where services were completed; PO boxes are not accepted. The NPI# must be the provider who performed the services. The Federal Tax ID (TIN) must be the billing entity for the location.
Proof of Service(s)	CMS 1500 claim form or itemized receipt showing services rendered, including date(s) of service, CPT procedure codes with modifiers, diagnosis codes, and dollar amounts billed.
Proof of Payment	Document(s) that demonstrates payment made by the member received by the provider of service. Example: Itemized receipt on provider office letterhead showing services rendered, including date(s) of service, CPT procedure codes with modifiers, diagnosis codes, and dollar amounts paid.

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## Checklist

I have confirmed my plan includes coverage for out-of-network providers.

I have confirmed my out-of-network provider has not received payment directly and/or does not plan to file a claim on my behalf.

I have enclosed proof of services received ([see Help Sheet / FAQ](#)).

I have enclosed proof of my payment for services not related to copay, coinsurance, or deductible ([see Help Sheet / FAQ](#)).

I understand that this is not a guarantee of payment (see Help Sheet / FAQ "[What Is My Responsibility?](#)").

I have completed and signed this form in its entirety.

Envolve Benefit Options complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Envolve Benefit Options does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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