*Vision*Care Benefit
Member Reimbursement Form

Instructions

1. Please use this ***Vision*Care** benefit member reimbursement form to request reimbursement for the ***Vision*Care benefit only**. For other eyewear coverage that may be available due to a medical condition (post-cataract or retinal detachment surgery or Keratoconus), please refer to "Special Conditions" on the other side of this form.
2. Please read and complete this form.
3. Attach **proof of payment** and an itemized bill from the provider which includes the date of service, description of services provided, provider's tax ID number and amount paid.
4. Send completed form, bill and proof of payment in the self-addressed, postage-paid envelope provided.

Member Information

Subscriber Name: First____________________Middle Initial__Last ____________________ Address

____________________________________City________________State__________Zip __________

Patient's Name: First____________________Middle Initial__Last ____________________ Member

Identification No. (from ID card)________________________Date of Birth______________Sex (m/f)_____

Claim Information

Check (√) items that apply	Description of Services	Procedure No.	No. of Services	Place of Service	Date(s) of Services Rendered	Amount Billed
	eyeglass frames or lenses	92390	1	VH		
	contact lens services (including fitting)	92310	1	VH		

Diagnosis

V20.0 - routine vision correction ❒ yes ❒ no
If no, please see other side for "special conditions" section

TOTAL DUE MEMBER $

Provider Information

Name of Provider ________________________________

Address______________________________City________________State__________Zip __________

Mail to: HPHC Claims • P.O. Box 699183 • Quincy, MA 02269-9183 • 1-888-333-4742

Special Conditions

For certain medical conditions, such as Keratoconus, post-retinal detachment surgery or post-cataract surgery, eyewear benefits may be available. Please refer to your Member Agreement for details. If you have a claim for eyeglasses or contact lenses for special conditions that are covered under the medical benefit please do the following:

1. Have your optical provider complete a standard claim form and submit the claim for processing. **Do not use the *Vision*Care benefit member reimbursement form to request initial payment for eyewear obtained due to these conditions.**
2. If there is a remaining balance due to the provider after Harvard Pilgrim pays the claim, use this *Vision*Care benefit member reimbursement form to request reimbursement for the balance due under your *Vision*Care benefit (up to the benefit limit). Attach a copy of the itemized bill from your optical provider that includes:
   - original dollar amount of services provided;
   - the appropriate diagnostic code(s):
     - Post-cataract surgery (366.5 - 366.9 or V43.1)
     - Post-retinal detachment surgery (367.3 - 367.31 or V45.6)
     - Keratoconus (371.60 - 371.62)
   - amount of Harvard Pilgrim payment;
   - amount you still owe to provider after Harvard Pilgrim payment.

Assignment of Benefits

PAYMENT WILL BE MADE DIRECTLY TO YOU, IF YOU SIGN BELOW.

I authorize reimbursement of benefits to myself for the services described above or as indicated on the enclosed bill. I understand that I am financially responsible to the provider for charges in excess of the Plan's schedule or charges not covered by my benefit plan.

Subscriber's Signature   Date

I hereby apply for benefits and certify that the above information is complete, true and correct. To all physicians and other medical professionals, hospitals, and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators: You are authorized to provide the Plan and any benefit plan administrators from consumer reporting agencies, attorneys and independent claim administrators acting on the Plan's behalf, with information concerning medical care, advice, treatment or supplies to the Patient, and any employment-related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

CLAIM CANNOT BE PROCESSED WITHOUT MEMBER'S SIGNATURE

Subscriber's Signature   Date   Dependent Patient's Signature   Date