

**Vision Plan
Out of Network Claim Form**

Today's Date	Date of Service
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Employee's Name	Employee's Unique Identification Number
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Address where check should be mailed (address, city, state, zip code)

Patient's Name	Patient's Relationship to Employee	Patient's Date of Birth
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Employee Signature

Date

RETURN THIS FORM WITH A COPY OF YOUR PAID, ITEMIZED RECEIPT TO:

**UnitedHealthcare Vision
ATTN: Claims Department
P.O. Box 30978
Salt Lake City, UT 84130**

Fax: (248) 733-6060

If you have any questions on your vision coverage, please call our Customer Service Department at (800) 638-3120. Please have the employee's unique identification number ready.