EyeMed
4000 Luxottica Place
Cincinnati, OH 45040
Visit us online at www.eyemed.com
Fax claim form to 866.293.7373

Medically Necessary Contact Lens Out-of-Network Claim Form

Provider Reimbursement

Patient Information (Required)

Last Name	First Name	Middle Initial

Street Address	City	State	Zip Code

Birth Date (*MM/DD/YYYY*)	Telephone Number (with area code)
- -	- -
Member ID # (*if applicable*)	Relationship to the Subscriber Self ☐ Spouse ☐ Child ☐ Other ☐

Subscriber Information (Required)

Last Name	First Name	Middle Initial

Street Address	City	State	Zip Code

Birth Date (*MM/DD/YYYY*)	Telephone Number (with area code)
- -	- -
Vision Plan Name	Vision Plan/Group #
Date of Service (**Required**) (*MM/DD/YYYY*) - -	Authorization # :

Medically Necessary Codes (Includes Contact Lens Evaluation/Fit and Follow and Materials) - SUBMIT AS PRIMARY

Check ALL CODES that apply to final Rx, as published in the EyeMed Professional Provider Manual

☐ **Anisometropia** **92310AN** Select this if Rx is 3D in meridian powers. Check this box and the box below. Reimburses up to $700 for services and materials.	☐ **High Ametropia** **92310HA** Select this if Rx exceeds -10D or +10D in meridian powers in either eye. Reimburses up to $700 for services and materials.	☐ **Keratoconus** **92072** Select this if diagnosis is Keratoconus. Check this box and the one below. Reimburses up to $1200 for services and materials.	☐ **Vision Improvement** **92310VI** **Keratoconus is absent** Select this for members whose vision can be corrected by two lines on the visual acuity chart. Reimburses up to $2500 for services and materials.
☐ **ICD-9 Code** **367.31**		☐ **ICD-9 Code** **371.60**	
U&C $	**U&C $**	**U&C $**	**U&C $**

Complete Information Below for Members Covered by Pediatric Vision Benefits - CALIFORNIA ONLY

☐ **Pediatric Aniridia** **92310AI** (CA only) Reimburses up to $3730 for services and materials.	☐ **Pediatric Aphakia** **92310AP** (CA only) Reimburses up to $5800 for services and materials.	
☐ **ICD-9 Code** **743.45**	☐ **ICD-9 Code** **379.31**	
U&C $	**U&C $**	

Request for Material Reimbursement (Enter U&C Amount Charged) - SUBMIT AS SECONDARY

☐ **SO500** $	☐ **V2500-V2503** $	☐ **V2520-V2523** $
☐ **V2599** $	☐ **V2510-V2513** $	☐ **V2530-V2531** $

Important Information

I hereby understand that withour prior authorization from Eyemed for services rendered, I may be denied reimbursement for submitted vision care services for which I am eligible. I hereby authorize any insurance company that the informaiton furnished by me in support of this claim is true and correct. Fax claim form to 866.293.7373.

Member Signature:	**Date:**

Effective 11/14/13