

Out-of-Network Vision Claim Form

Most Health Net Vision plans let you choose any provider. The best and lowest cost options are often in-network. Of course, you can use an out-of-network provider, but your benefits get reduced. Please check your plan details to ensure coverage. EyeMed Vision Care Inc., LLC manages Health Net Vision plans.

We have many eye doctors in your area. Before you visit a provider, ask if they are part of your network. Please work with their office to submit your claim.

If you choose to go out-of-network, follow the steps below. If you miss or omit information, it may result in a delayed payment or a returned form.

Send this form to Health Net Vision within 15 months from the date of service.

How to make sure you receive a reimbursement.

1. When you go to an out-of-network provider, you must pay for services and/or materials at that time. Health Net Vision will pay you back for services allowed under your plan.
2. Please fill out all fields. Find your plan information on your ID card or ask your human resources contact.
3. Health Net Vision only accepts detailed receipts with the services and cost for each item. Your name and the date of service must show on the receipt. You need to pay the total amount upfront. You can include handwritten receipts on the provider letterhead. Attach all receipts to the form. If not in U.S. dollars, share what type of money you used.
4. Don't forget to sign the claim form below.

Send the form and receipts to:

Health Net Vision
Attn: OON Claims
PO Box 8504
Mason, OH 45040-7111
Fax number: 866-293-7373
Email address: oonclaims@eyemedvisioncare.com

Once Health Net Vision gets your form, allow at least 14 calendar days to process. Claims will process in the order of receipt. You will get a check and/or explanation of benefits (EOB) within 7 calendar days of your claim process date.

Please contact the customer service number on the back of your ID with questions.

If you submit an application or file a claim with false information, that is insurance fraud.

All Patient and Subscriber Information is required for Claims Processing

Patient Last Name (Required) <input type="text"/>			
Patient First Name (Required) <input type="text"/>		MI <input type="text"/>	Birth Date (MM/DD/YYYY) <input type="text"/> - <input type="text"/> - <input type="text"/>
Street Address <input type="text"/>		City <input type="text"/>	State <input type="text"/> Zip Code <input type="text"/>
Patient Member ID: <input type="text"/>		Relationship to the Subscriber : <input type="checkbox"/> Self <input type="checkbox"/> Dependent	

Doctor or Store Name where you received service (Required) :

Subscriber Last Name (Required)

















Subscriber First Name (Required) <input type="text"/>		MI <input type="text"/>	Birth Date (MM/DD/YYYY) <input type="text"/> - <input type="text"/> - <input type="text"/>
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Street Address <input type="text"/>		City <input type="text"/>	State <input type="text"/> Zip Code <input type="text"/>
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Vision Plan Name <input type="text"/>	Date of Service -Required (MM/DD/YYYY) <input type="text"/> - <input type="text"/> - <input type="text"/>
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Vision Plan Group # <input type="text"/>	Subscriber Member ID # <input type="text"/>
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REQUIRED- Request For Reimbursement –Enter Amount Charged. Remember to include itemized paid receipts:

Service Type	Amount Charged	Lens Type:	Lens Options: (if purchased)	Amount Charged
Exam 	\$ <input type="text"/>	<input type="checkbox"/> Single 	Anti-Reflective 	\$ <input type="text"/>
Refraction 	\$ <input type="text"/>	<input type="checkbox"/> Bifocal 	Polycarbonate 	\$ <input type="text"/>
Frame 	\$ <input type="text"/>	<input type="checkbox"/> Trifocal 	Scratch 	\$ <input type="text"/>
Contact Lens 	\$ <input type="text"/>	<input type="checkbox"/> Progressive 	Tint 	\$ <input type="text"/>
Contact Lens Fitting 	\$ <input type="text"/>	<input type="checkbox"/> Prem Prog 	UV 	\$ <input type="text"/>
Lenses	\$ <input type="text"/>	Other \$	Roll & Polish 	\$ <input type="text"/>

Required: Enter Total Amount Paid as shown on receipt, excluding sales tax \$, .

I hereby understand that without prior authorization from Health Net Vision for services rendered, I may be denied reimbursement for submitted vision care services for which I am not eligible. I hereby authorize any insurance company, organization employer, ophthalmologist, optometrist, and optician to release any information with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct.

Member/Guardian/Patient Signature (not a minor) _____ Date: _____



Revision date 4/2017

Fraud warning statements

FRAUD NOTICE: For the states of **AL, AZ, AR, CA, CO, DE, DC, FL, GA, IN, KS, KY, LA, MD, ME, NC, NE, NJ, NM, OK, OR, PA, RI, TN, TX, VA, VT, WA, and WV**, please refer to the following fraud notices:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona Fraud Notice: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Oregon, Vermont: Any person, who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

Kansas: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Nebraska: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a material false or deceptive statement is guilty of insurance fraud.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

North Carolina: Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.