



**Vision Plan
Out of Network Claim Form**

Today's Date	Date of Service	
Employee's Name	Employee's Social Security Number	
Address where check should be mailed (address, city, state, zip code)		
Patient's Name	Patient's Relationship to Employee	Patient's Birthdate

Employee Signature Date

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

**UnitedHealthcare Vision
ATTN: Claims Department
PO Box 30978
Salt Lake City, UT 84130**

Fax: 248-733-6060

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