Opticare of Utah Out of Network Reimbursement Request

Insured Member Identification Number	______
Insured Member's Full Name	______
Insured Daytime Phone Number	______
Insured Address	______
Patient Name	______
Date of Service	______
Place of Service - Provider Name	______
Provider Phone Number	______
Provider Address	______

Itemized Price(s) Paid		
	Examination	______
	Dilation	______
	Contact Fitting	______
	Lenses	______
	Scratch Coating	______
	UV Coating	______
	Coatings and Extras	______
		______
	Frame	______
	Contact Lenses	______

Please submit completed form & itemized receipt to:

Opticare of Utah
1901 West Parkway Blvd
Salt Lake City, UT 84119
Fax (801) 954-0054
Toll Free Fax (888) 547-4227
service@opticareofutah.com

Questions or Comments : (800) 363-0950
www.opticareofutah.com

Policy and Procedures

Opticare of Utah will process your claim within 30 days from the date received. All information requested is required to process your claim completely. If information is missing, the claim will not be processed completely and may add time to the receipt of payment. Opticare of Utah will mail your check to the insured's mailing address listed on file. If the address may have changed recently, please contact the insured's Human Resource department to have them submit the address change to Opticare of Utah for updating.

Out of Network Provider must be a licensed Optician, Optometrist, or Ophthalmologist to qualify - No website/online purchases are covered. Full Allowance qualification is based on retail pricing. Please see Plan Outline.

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