OUT-OF-NETWORK VISION CARE CLAIM FORM

Dear Member:

You have requested an Out-of-Network claim form for vision services to be provided outside of the TruAssure Vision Care network. Most TruAssure plans allow members to select the provider of their choice, in or out of the network.

TruAssure has designed benefit plans to deliver quality care, matched with comprehensive benefits, at the most affordable cost, through our In-Network providers. Members also have the flexibility to visit an Out-of-Network provider, with a possible reduction in benefits. If you choose to go to an Out-of-Network provider, please complete the following steps prior to submitting your Out-of-Network claim form:

1. Visit your provider of choice to receive vision care services. Please remember that you are responsible for payment of vision care services at the time of service. TruAssure will reimburse you for authorized services according to your plan design. Please consult your plan design for the listing of qualified services and their reimbursement amounts.
2. Complete the Patient Information portion of your claim form.
3. Complete the Plan Information Portion of your claim form. This information can be found by contacting your Human Resources Department.
4. Complete the Request for Reimbursement portion of the form.
5. Sign the claim form. If the patient is a minor, the parent or legal guardian is required to sign the claim form.
6. Attach itemized receipts from your provider to the claim form. Please include the following breakdown of costs:
   EXAM
   FRAMES
   LENSES (specific prescription and type of lenses)
   CONTACT LENSES (specific prescription and type of lenses)
7. Mail the claim form to:

   TruAssure Vision Care Claims Processing
   c/o EyeMed Vision Care Services
   P.O. Box 8504
   Mason, OH 45040-7111

   or fax all of the information to (866) 293-7373.

If you want to be pre-authorized for vision care benefits, please contact TruAssure toll-free at 1-866-723-0513. The Customer Care Center is available Monday through Saturday 7:00 a.m. to 10:00 p.m. CST and Sunday from 10:00 a.m. to 7:00 p.m. CST. After hours, please leave a voice mail request, including patient name, Member ID, the requested services and your daytime telephone number. We will confirm your eligibility for vision care benefits.

If you submit incomplete documentation, a delay in reimbursement may occur. Without prior authorization for services, there is a risk that you may not receive the entire benefit you are requesting reimbursement for.

Thank You,

TruAssure Insurance Company

This TruAssure vision care plan is administered by

OUT-OF-NETWORK VISION CARE CLAIM FORM

For Internal Use Only	CLAIM NUMBER
	AUTHORIZATION NUMBER

DATE OF SERVICE _____ /_____ /_____

PATIENT INFORMATION

PATIENT NAME (Last, First, MI)			
ADDRESS			
CITY		STATE	ZIP CODE
SEX	DATE OF BIRTH (mm/dd/yyyy)	OCCUPATION	
HOME PHONE		WORK PHONE	

PLAN INFORMATION

EMPLOYEE NAME (Last, First, MI)	
EMPLOYER	
PLAN NAME	
MEMBER SS# / ID#	MEMBER DOB (mm/dd/yyyy)
PATIENT RELATIONSHIP TO EMPLOYEE	

REQUEST FOR REIMBURSEMENT

An itemized receipt must be attached

RECEIVED SERVICE FOR: (please circle those approved)	EXAM	CONTACTS*	FRAMES	LENSES
AMOUNT CHARGED FOR SERVICES:	$_____	$_____	$_____	$_____

*Please include the Fit and Follow Up portion of your exam in the Contact Lens Amount

If Lenses are being submitted, please circle type of lens: Single Bifocal Trifocal Progressive Other

I HEREBY UNDERSTAND THAT without prior authorization from TruAssure Insurance Company for services rendered, I may not be reimbursed for submitted vision 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 / PATIENT SIGNATURE (Not a Minor) _____

DATE_____

Please mail the claim to TruAssure Vision Care, c/o EyeMed Vision Care, Attn: OON CLAIMS, P.O. Box 8504, Mason, OH 45040-7111. If you would like to fax the information, send to (866) 293- 7373.