UnitedHealthcare Vision

VISION PLAN
OUT OF NETWORK CLAIM

Today's Date	Date of Service	
Employee's Name	Employee's Unique Identification Number	
Address Where Check Should Be Mailed (Address, City, State, Zip Code)		
Patient's Name	Patient's Relationship to Employee	Patient's Date of Birth
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 our
Customer Service Department at (800) 638-3120.
Please have the employee's unique identification number ready.