VISION CLAIM TRANSMITTAL

Claim Address:
UnitedHealthcare
PO Box 740800
Atlanta, GA 30374-0800

Employer Name: Group (Policy) Number:

Vision Care Providers – please make sure you have indicated the patient's diagnosis, date of service, and circled the appropriate procedure codes in Section E prior to submitting this claim.

A. MEMBER/EMPLOYEE INFORMATION (Please include your member ID on all documentation):

Member # (SSN)	Last Name:	First Name:	MI:
Home Address	City	State	Zip Code:

B. PATIENT INFORMATION:

Last Name:	First Name:	MI:	Date of Birth:
Sex M ☐ F ☐	Relationship to Member:	Full Time Student Yes ☐ No ☐	School Name:

C. ACCIDENT INFORMATION:

Work Accident? Yes ☐ No ☐	Auto Accident? Yes ☐ No ☐	Date Accident Occurred: / /
How did the accident occur:		

D. OTHER INSURANCE

Is the patient covered by another insurance plan? Yes ☐ No ☐	If yes, please complete the following:
Name of person Carrying other insurance:	Date of Birth: / /
SSN #:	Name of the Other Insurance Carrier
Policy Number:	Employer Name:

E. THIS SECTION TO BE COMPLETED BY PROVIDER
PLEASE CHECK APPROPRIATE BOXES AND INDICATE APPLICABLE CHARGES:

Exams

Diagnosis: V720

Date of Exam: ____

	Code	Charge
New Patient	92002	$
	92004	$
Established Patient	92012	$
	92014	$
Refraction	92015	$
	92310	$

Lenses

Date of Purchase: ____

	Code	Charge
Single Vision	V2101	$
Bifocals	V2200	$
Trifocals	V2300	$

Frames

Date of Purchase: ____

	Code	Charge
Standard	V2020	$
Deluxe	V2025	$

Contact Lenses

Date of Purchase: ____

	Code	Charge
PMMA	V2500	$
Gas Permeable	V2510	$
Hydrophilic	V2520	$
Scleral	V2530	$

Description:		
Total Charges $	Amount Paid by the Employee $	
Name of Provider who Performed the Services:	Phone (Area Code):	
Address:	City-State-Zip Code:	
Provider's Signature:	Tax ID No.: ____	Must be Furnished
Date: / Degree/Title:	Employee ID No.: ____	Under Authority of Law

F. ASSIGNMENT OF BENEFITS

Please sign below only if you want UnitedHealthcare to pay benefits directly to the provider of vision service:

Patient Signature:	Member Signature:	Date:

NOTE: Please do not attach any receipts or bills to this form. Make sure form is completely filled out and mail only this form to the above address.