

**Vision Plan
Out of Network Claim Form**

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
P.O. 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.