# Member Vision Claim Submission Form

**UMR**
A UnitedHealthcare Company

**IMPORTANT:** We recommend all vision receipts be submitted online. You can do this by signing in to **umr.com.** Once you're signed in, select the **Claims** drop-down menu in the blue navigation bar. Under **Other tools**, select **Submit a claim**. Then, select **Submit an online claim**.

To be considered a valid claim, submit your receipt or itemized statement along with this completed claim form containing the required information. Please refer to filing instructions included for the supporting documentation required for claim submission. **Sufficient documentation is required for the claim to be processed.**

## Personal information

Name of employer _____

Name of employee _____

Patient's name _____

Employee phone number and/or email address _____

Issue payment to          Member          Provider

Facility name _____

Provider name _____

Provider address _____

Plan group number _____

Member ID _____

Date of birth ____ / ____ / ____
MM      DD      YYYY

Date of purchase/service: ____ / ____ / ____
MM      DD      YYYY

Provider
9-digit tax ID#* _____

*Required field – See filing instructions for online TIN or contact your provider to obtain information.

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*Check all that apply.* List dollars paid in front of each checked item. Make sure the total paid matches the attached receipt. Please note: All service types may not be covered under your plan. When entering the total amount paid, subtract any discounts, shipping and handling/delivery fees or sales tax.

| Reason for vision exam (check one): | Routine annual vision exam          Medical vision exam (i.e., glaucoma, diabetic) <br><br> Provide reason for visit: _____ |
|---|---|

## Charges incurred:

Vision exam, paid $ _____          Refraction, paid $ _____

| Lenses: | Single lenses, paid $ _____ | Progressive lenses, paid $ _____ |
|---|---|---|
| | Bifocal Lenses, paid $ _____ | Lens coating, paid $ _____ |
| | Trifocal lenses, paid $ _____ | Other, paid $ _____ |
| | Lenticular lenses, paid $ _____ | Description: _____ |
| **Contact lenses:** | Lens fitting, paid $ _____ | Contacts, paid $ _____ |
| **Glasses:** | Frames, paid $ _____ | |
| | Safety glasses, paid $ _____ | |

Total amount paid: $ _____

*(Continued)*

## Please describe services rendered if you are unable to match to categories on previous page:

_____

_____

_____

## Filing instructions:

**You may submit your claim to UMR by one of the following methods**

Fax:
**855-444-2896**

Mail:
**Send to the address
on your UMR ID card**

1. Use this form to file a claim for any eligible vision charges. Please print clearly with black ink completing all required fields.

2. Attach your itemized statement (or fully legible copy of receipts) to the back of this form.
   Keep a copy for your records.
   a. Please indicate the member ID number on any attachments.
   b. Staple any attachments to the back of the claim form, not the front.

3. Please use a separate claim form for each family member.

4. Use your UMRs ID card for:
   a. Name of employer
   b. Plan group number
   c. Name of member (as it appears on the ID card)

5. Patient name and date of birth must match UMR's eligibility file.
   a. For example, if your name is Eugene Smith on your employer enrollment form, claim must state Eugene, not Gene.

6. Name, address, and Tax ID number (TIN) of the provider of service is required. If the provider's Tax ID number (9 digit number) is not on your copy of the itemized statement or receipt, you can contact their office to obtain it.

7. Balance due statements are not valid statements or receipts. See above for information needed to constitute a valid claim.

Below are some confirmed online Provider TINs. Please use only when appropriate:

| Facility | TIN |
|---|---|
| 1-800 Contacts | 870571643 |
| Frames Direct | 760459412 |
| Glasses USA | 981385007 |
| Warby Parker | 800423634 |
| Zenni | 454185057 |
| Contacts Direct | 311339854 |
| EyeBuyDirect | 203678882 |