Opticare of Utah Out of Network Reimbursement Request

Insured Member Identification Number ______________________

Insured Member Name ______________________

Insured Daytime Phone Number ______________________

Insured Address ______________________

Patient Name ______________________

Date of Service ______________________

Place of Service - Provider Name ______________________

Provider Phone Number ______________________

Provider Address ______________________

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Cost

Examination ______________________

Dilation ______________________

Contact Fitting ______________________

Lenses ______________________

Scratch Coating ______________________

UV Coating ______________________

Coatings and Extras ______________________

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Frame ______________________

Contact Lenses ______________________

Please submit completed form & itemized receipt to:

Opticare of Utah
1901 West Parkway Blvd
Salt Lake City, UT 84119
Fax (801) 954-0054

Questions or Comments : (801) 886-2020
(800) 363-0950
service@opticareofutah.com