Out of Network Reimbursement Request

Insured Member Identification Number ______________________

Insured Member's Full Name ______________________

Insured Daytime Phone Number ______________________

Insured Address ______________________

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Patient Name ______________________

Date of Service ______________________

Place of Service - Provider Name ______________________

Provider Phone Number ______________________

Provider Address ______________________

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Itemized Price(s) Paid -		
	Examination	
	Dilation	
	Contact Fitting	
	Lenses	
	Scratch Coating	
	UV Coating	
	Coatings and Extras	
	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
Toll-Free Fax (888) 547-4227

Questions or Comments :

www.opticareofutah.com
service@opticareofutah.com
(801) 869-2020
1-800-363-0950

Policy and Procedures

Opticare will process your claim within 30 days from receipt. All information requested is required to completely process your claim. If information is missing, the claim will not be processed completely and may add time to the receipt of your check. Opticare will mail your check to the insured's address listed above. If this address may change within the next 30 days, please contact Opticare of Utah with the new address.