UnitedHealthcare®

Fax: 888-776-6519
City of Austin HRD
C/O UnitedHealthcare
PO Box 1088
Austin, TX 78767

Vision Claim Form

This claim form is to be used for reimbursement to the member for the contact lens exam and fitting fee.

Employee/Patient Information

Member name _____ ID #____–____–____ Date of birth ____/____/____

Member address _____ Check if new address ☐

Member phone number ( ) _____ Status ☐ Active ☐ Retired ☐ Continued (COBRA)
Area Code Number

Patient name _____ Date of birth ___/___/___ Relationship _____

Total charges	$	Date of service / /
ICD10/Diagnosis Code	H52.03	

Claim Information – Please attach receipt to back of claim form.

Contact lens fitting:	☐ 92310 Contact lens fitting	Contact lens exam:	☐ 92015 Contact lens exam

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

Employee/Patient signature: _____ Date____/____/____

• Attach your receipt to this completed form and mail it to UnitedHealthcare at the address below:

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