UnitedHealthcare®

Fax: 888-776-6519
UnitedHealthcare -Medical Claims
PO Box 30555, Salt Lake City, UT 84130-0555

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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