Heritage vision plans

CLAIM FORM
OUT OF NETWORK SERVICES

As a Heritage Vision Plans member, you will maximize benefits and reduce out-of-pocket costs by choosing a Heritage provider. If your plan provides out of network benefits and you choose to use an out of network provider, here are the steps to take:

1. Call our Customer Service Center toll free at **800.252.2053** to verify your eligibility.
2. Make an appointment with the provider of your choice.
3. When your examination is complete and you have been fitted for necessary eyeglasses or contact lenses, pay the charges in full.
4. Request an itemized receipt. Receipt must indicate the services provided and the amount charged for each service.
5. Complete all sections of this Claim Form, sign and submit the form, along with your itemized receipt(s) using one of these methods:

Mail to:
Heritage Vision Plans, Inc.
Attention: Claim Processing
One Woodward Avenue, Suite 2020
Detroit, MI 48226
Fax to: **313.863.1189**
Email to: **eligibility@heritagevisionplans.com**

Out of network benefits are subject to the same eligibility, frequency, limitation and exclusion provisions of the plan, and are in lieu of in network services.

Payment will be sent within 30 days of receiving your claim. Any missing or incomplete information may result in delay of payment. Refer to your Benefits at a Glance for reimbursement and timely filing guidelines.

For inquiries regarding your submitted claim, call our Customer Service Center toll free at **800.252.2053** or send an email to **eligibility@heritagevisionplans.com.**

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EMPLOYEE INFORMATION:

Employer Name/Group:	
Employee Name:	**Date of Birth:**
Member ID or Last 4 of SSN:	**Phone Number:**

ADDRESS:

Street Address:	**Apt or Unit#:**	
City:	**State:**	**Zip:**

PATIENT INFORMATION

Name of Patient Serviced:	**Date of Birth:**
Relationship to Employee: Self ☐ Spouse ☐ Child ☐ Other	

SERVICE INFORMATION

Date of Service:	**Place of Service:**	
Street Address:	**Phone Number:**	
City:	**State:**	**Zip:**

SERVICES RECEIVED

☐ Exam	Provider Type: ☐ OD ☐ MD	$
☐ Lenses	☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Progressive ☐ Other	$
☐ Lens Options	Describe:	$
☐ Frame		$
☐ Contacts	☐ Elective/Cosmetic (Includes Disposable) ☐ Medically Necessary (Requires Pre-Approval)	$
☐ Contact Fit		$
☐ Other		$

I hereby understand that I may be denied reimbursement for submitted services for which I am not eligible. I hereby authorize any insurance company or service provider to release any information with respect to this claim. The information supplied by me or on my behalf is true and accurate to the best of my knowledge.

Member/Patient Signature (Not A Minor) **Date:**