



# Essential Vision

## Out-of-Network Claim Reimbursement

### **You are encouraged to seek eye care from an in-network Essential Vision provider, administered by Heritage Vision Plans.**

As a Essential Vision member, you will maximize benefits and reduce out-of-pocket costs by choosing a Heritage Vision Plan 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 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: Claims Processing  
One Woodward Avenue, Suite 2020  
Detroit, MI 48226

**Email:** [eligibility@heritagevisionplans.com](mailto:eligibility@heritagevisionplans.com)

Be sure to keep a copy of your form, receipts, and statements for your records. Payment will be sent within 30 days of receiving your claim. Any missing or incomplete information may result in delay of payment.

**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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	

**SERVICE INFORMATION**

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

**SERVICES RECEIVED**

<input type="checkbox"/> Exam	Provider Type: <input type="checkbox"/> OD <input type="checkbox"/> MD	\$
<input type="checkbox"/> Lenses	<input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Progressive <input type="checkbox"/> Other	\$
<input type="checkbox"/> Lens Options	Describe:	\$
<input type="checkbox"/> Frame		\$
<input type="checkbox"/> Contacts	<input type="checkbox"/> Elective/Cosmetic <small>Includes Disposable</small> <input type="checkbox"/> Medically Necessary <small>Requires Pre-Approval</small>	\$
<input type="checkbox"/> Contact Fit		\$
<input type="checkbox"/> 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:**