ONONDAGA COUNTY FORM FOR UnitedHealthcare

VISION CARE (OFFICE VISIT) AND HARDWARE CLAIM REIMBURSEMENT

MEMBERS NAME: _____

ID NUMBER: _____

REASON FOR REQUEST: _____

_____

Attach copy of itemized invoice including CPT code and Diagnosis codes with

Proof of payment (i.e. cancelled check, other credit card statement, cash receipt, etc.)

Mail the request to the address listed below, and allow up to 60 calendar days to process the request:

Claim Reimbursement

PO Box 31362

Salt Lake City, UT 84131-0362

SIGNATURE_____ DATE _____

*Please note reimbursement request for **co-pays** for the above services need to be sent on an

OPTUM Reimbursement Request Form

*HARDWARE CAN BE REIMBURSED UP TO $130.00 EVERY 24 MONTHS YEARS OR $175.00 CONTACT LENSES EVERY 24 MONTHS