VISION CLAIM TRANSMITTAL (Used to Submit Glasses, Frames, Lenses and Contacts Only)

Claim Address:
UnitedHealthcare

Advantage Plus Plan only

PO Box 30555
Salt Lake City, UT 84130-0555

Employer Name: Collin County **Group (Policy) Number: 0229670** **Fax 801-567-5498**

Vision Care Providers – please make sure you have completed all of Section C prior to submitting this claim.

A. EMPLOYEE INFORMATION (Please include your name, member ID and policy number on ALL documentation you submit with this claim):

Member # (SSN or Alt ID)	Last Name:	First Name:	MI:
Home Address	City	State	Zip Code:

B. PATIENT INFORMATION:

Last Name:		First Name:	MI:
Sex M ☐ F ☐	Date of Birth:	Relationship to Member:	

C. CLAIM INFORMATION

DATE OF SERVICE: _____

****Please circle****
Diagnosis Code: V72.0 prior to 10/1/15
Diagnosis Code : Z01.00 10/1/15 and after

Place of Service: 11 (Office)

****Hardware benefit with medical plan****

LENSES**

Single Vision	V2101	$_____
Bifocals	V2200	$_____
Trifocals	V2300	$_____
Lenticular	V2121	$_____
OTHER(list HCPC)	_____	$_____

FRAMES**

Standard	V2020	$_____
Deluxe	V2025	$_____
OTHER(list HCPC)	_____	$_____

CONTACTS**

PMMA	V2500	$_____
Gas Permeable	V2510	$_____
Hydrophilic	V2520	$_____
Scleral	V2530	$_____
OTHER(list HCPC)	_____	$_____

****CIRCLE APPROPRIATE CODES & ENTER AMOUNT**

Total Charges $_____ **Amount Paid by the Employee** $_____

ALL PROVIDER INFORMATION IS REQUIRED AND MUST BE COMPLETED

Name of Provider who Performed the Services:	Phone (Area Code):
Address:	City-State-Zip Code:
Provider Tax ID No. (***Provider must furnish under authority of law):***	

D. PROVIDER INFORMATION (ONLY NEEDED IF FORM IS BEING COMPLETED BY THE PROVIDER)

Provider's Signature:	Provider Degree/Title:	Date:

Assignment of Benefits	**Please sign below if you want UnitedHealthcare to pay benefits directly to the provider for the purchase of hardware**
Date:	Subscriber Signature: (To authorize benefits to be paid to the provider)

Please ensure you have not left any information blank and attach all receipts and itemized bills. Also, be sure to write the patients name, UHC ID# and Policy# on each separate page being submitted. MAIL : United Healthcare - PO Box 30555 - Salt Lake City, UT 84130-0555