MEMBER REIMBURSEMENT VISION CLAIM FORM

envolve Benefit Options

STOP!

Before you proceed with this request, consult your Summary of Benefits. Only members with out-of-network benefit coverage will be considered for reimbursement.

Instructions

1. Please complete one form per family member per provider.
2. Use this form for vision claims only.
3. You may need your healthcare provider to supply information for this form, including the **CPT code**(s) and **diagnosis code**(s). We suggest you bring this form with you to your appointment. Please refer to the Help Sheet for more information.
4. To request reimbursement, please submit the following to the address listed at the bottom of this form (any missing information may result in delay or denial of the request):
   a. This completed and signed reimbursement form
   b. Proof of services rendered
   c. Proof of payment for the services being requested for reimbursement (copy of a detailed bill, or superbill with provider's letterhead are preferred)
5. Most completed reimbursement requests process within 60 days.
6. Reimbursement will be sent to the address on record.
7. Keep a copy of all receipts and documents for your records.

Wellcare

- ☐ Alabama
- ☐ Arkansas
- ☐ Georgia
- ☐ Illinois
- ☐ Indiana
- ☐ Kansas
- ☐ Louisiana
- ☐ Massachusetts
- ☐ Mississippi
- ☐ Missouri
- ☐ Nebraska
- ☐ Nevada
- ☐ New Hampshire
- ☐ New Jersey
- ☐ New Mexico
- ☐ North Carolina
- ☐ Ohio
- ☐ Oklahoma
- ☐ Pennsylvania
- ☐ South Carolina
- ☐ Texas
- ☐ Washington

Ascension Complete

- ☐ Alabama
- ☐ Florida
- ☐ Kansas
- ☐ Illinois
- ☐ Indiana
- ☐ Michigan
- ☐ Tennessee
- ☐ Texas

Marketplace

- ☐ Arkansas
- ☐ New Hampshire
- ☐ North Carolina (Wellcare)
- ☐ Oklahoma
- ☐ Texas Community First

Other

- ☐ UPMC Pennsylvania

Please submit this form and all documentation to:
Envolve Benefit Options • Claims Department-Member Reimbursement • P.O. Box 7458 • Rocky Mount, NC 27804

MEMBER REIMBURSEMENT VISION CLAIM FORM

envolve Benefit Options

Instructions

Patient Member ID#:	Last Name:	First Name:	Middle Initial:	D.O.B. (MM/DD/YYYY):

Mailing Address (include city, state, and ZIP):

Telephone Number:	Does Patient have additional insurance? ☐ Yes ☐ No	Did other insurance make a payment: (If yes, include plan's EOB) ☐ Yes ☐ No	Patient Relationship to Subscriber/Patient ☐ Self ☐ Spouse ☐ Dependent

Claim Information

(This section must be completed. Your vision care provider may need to assist in completing this section.)

Healthcare Provider Name:	Telephone Number:	Provider NPI #:	Tax ID #:

Healthcare Provider Address, including City, State, and ZIP Code:

Diagnosis Code(s) (optional - if blank, Envolve will assume routine eye exam):

Service Type	Amount Charged
Exam **92014**	$ _____
Refraction **92015**	$ _____
Frame **V2020/V2025**	$ _____
Contact Lens **S0500**	$ _____
Contact Lens Fitting **92310**	$ _____
Other	$ _____

Lens Type	Choose One
Single **V2100**	☐
Bifocal **V2200**	☐
Trifocal **V2300**	☐
Fitting Fee **92340**	$ _____
Fitting Fee **92341**	$ _____

Lens Options (if purchased)	Amount Charged
Roll and Polish **V2702**	$ _____
Tint **V2745**	$ _____
Anti-reflective **V2750**	$ _____
Scratch Resistant **V2760**	$ _____
Polycarbonate **V2784**	$ _____
Total Amount Paid:	$ _____

Checklist

- ☐ I have completed and signed this form in its entirety.
- ☐ I have enclosed documents of Proof of Services received (see the help sheet for an example of proof of services).
- ☐ I have enclosed documents of Payment of Services – not related to copay or plan deductible (see the help sheet for an example of proof of payment).

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be canceled and I may be subject to criminal and/or civil penalties for false healthcare claims. I understand that reimbursement payment will be sent to the address on file and will contain information about the service (e.g., provider name, date, description of service). I also understand that Envolve Benefit Options may request any additional information it deems necessary to verify that services were received and payment was made.

Printed Member Name	Member Signature	Date

Please submit this form and all documentation to:
Envolve Benefit Options • Claims Department-Member Reimbursement • P.O. Box 7458 • Rocky Mount, NC 27804

MEMBER REIMBURSEMENT VISION CLAIM FORM - HELP SHEET/FAQ's

envolve Benefit Options

Question	Answer
What is this form used for?	This form is used to ask for payment for eligible vision care you have already received.
What is my responsibility?	Copayments, deductibles, coinsurance, and non-covered services will be patient responsibility. If you receive care from an out-of-network provider and the provider bills more than the Usual, Reasonable, and Customary charge, the member will not be reimursed the total coinsurance payment amount paid or any amount that is over the Usual, Reasonable and Customary charge. **THIS IS NOT A GUARANTEE OF PAYMENT.** Actual payment for covered service will be paid at the appropriate level according to your plan benefits and you may be billed for the difference between Envolve allowed amount and the providers billed charges.
What happens next?	After processing your claims, you will receive an Explanation of Benefits (EOB). The EOB explains the charges applied to your deductible (the fixed dollar amount you pay for covered services before the insurer starts to make payments) and any charges you may owe the provider. Please keep your EOB on file in case you need it in the future.
Who should I call if I need help completing this form?	Call the Member Services number on your health plan member ID card.

Field Name	Description
Subscriber Information	Subscriber is the person: Who enrolls in a plan and signs the membership application form on behalf of themselves and any dependents. In whose name the premium is paid.
Patient Member ID#	ID# with suffix, found on the front of the health plan member ID card.
Patient Name	Last and First names and Middle Initial of patient who received services.
Patient Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits). Include newborn's date of birth in the same box as the parent's.
Provider's Name, Address, Telephone Number, NPI #, Provider Federal Tax ID #	A provider includes, but is not limited to, hospitals, physicians, ophthalmologists, opticians, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers.
Diagnosis Code(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: The front and back of the canceled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made; a receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and amount paid.

Envolve Benefit Options complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Envolve Benefit Options does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Please submit this form and all documentation to:
Envolve Benefit Options • Claims Department-Member Reimbursement • P.O. Box 7458 • Rocky Mount, NC 27804