VISION CLAIM TRANSMITTAL

Claim Address:
UnitedHealthcare
PO Box 740800
Atlanta, GA 30374-0800

Employer Name: **Fairleigh Dickinson University** Group (Policy) Number: **700734**

Vision Care Providers – please make sure you have indicated the patient's diagnosis, date of service, and circled the appropriate procedure codes in Section E prior to submitting this claim.

A. MEMBER/EMPLOYEE INFORMATION (Please include your member ID on all documentation):

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

B. PATIENT INFORMATION:

Last Name:	First Name:	MI:	Date of Birth:
Sex M ☐ F ☐	Relationship to Member:	Full Time Student Yes ☐ No ☐	School Name:

C. ACCIDENT INFORMATION:

Work Accident? Yes ☐ No ☐	Auto Accident? Yes ☐ No ☐	Date Accident Occurred: / /
How did the accident occur:		

D. OTHER INSURANCE

Is the patient covered by another insurance plan? Yes ☐ No ☐	If yes, please complete the following:
Name of person Carrying other insurance:	Date of Birth: / /
SSN #:	Name of the Other Insurance Carrier
Policy Number:	Employer Name:

E. THIS SECTION TO BE COMPLETED BY PROVIDER
PLEASE CHECK APPROPRIATE BOXES AND INDICATE APPLICABLE CHARGES:

Diagnosis: Z01.00 or **Z01.01** (Please Circle One)

Place of Service: OFFICE

If the member purchases contacts online, please check off the appropriate box in the "Contact Lenses" section. Please also provide doctor's name, address, and phone number in space provided.

LENSES

Date of Purchase:__________

Single Vision	V2100	$
Bifocals	V2200	$
Trifocals	V2300	$
Lenticular	V2121	$
Other (Please Describe)		$

FRAMES

Date of Purchase: __________

Standard	V2020	$
Deluxe	V2025	$

CONTACT LENSES

Date of Purchase:__________

PMMA	V2500	$
Gas Permeable	V2510	$
Hydrophilic	V2520	$
Scleral	V2530	$

Description:

Total Charges: $ Amount Paid by the Employee: $

Name of Provider who Performed the Services: Phone (Area Code):

Address: City-State-Zip Code:

Provider's Signature: __________

I certify that the above services were rendered by me.

Date: Degree/Title:

Provider Tax ID No. or Provider SSN:__________

Must be Furnished under Authority of Law

F. ASSIGNMENT OF BENEFITS

Please sign below only if you want UnitedHealthcare to pay benefits directly to the provider of vision service:

Patient Signature:	Member Signature:	Date:

NOTE: Please do not attach any receipts or bills to this form. Make sure form is completely filled out and mail only this form to the above address.