

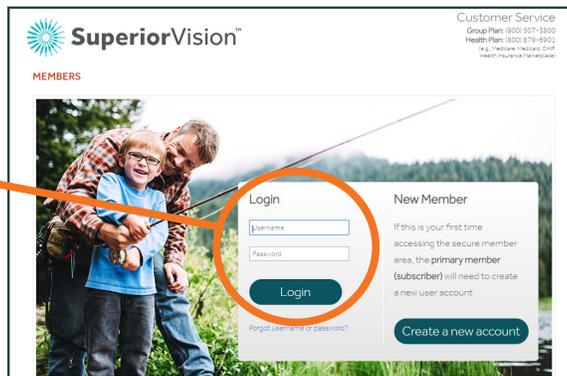
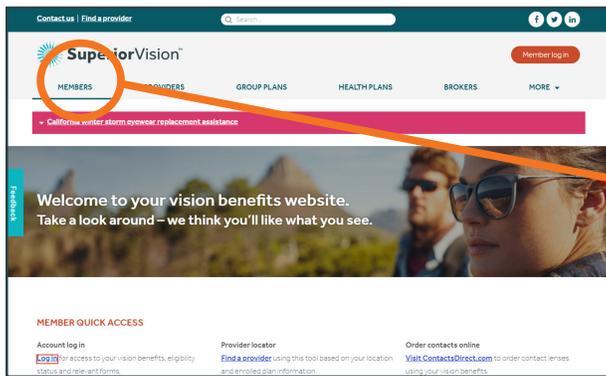


How to submit an out-of-network claim

Getting signed in

From **superiorvision.com**, select the "Members" option, then select "Log in". Enter your username and password to sign in.

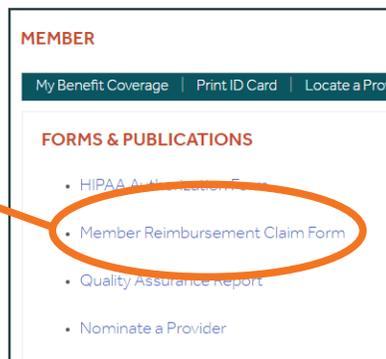
If you are a new member, create a new registration for access by clicking on the "Create a new account" button.



Finding the member reimbursement claim form

Once you are signed in, go to the "Forms & Pubs" tab in the top menu bar.

From the list of forms, select "Member Reimbursement Claim Form". Complete the attached PDF and mail or fax it to the address indicated on the form.



Member Reimbursement Claim Form

Use this form for reimbursement of services received from an out-of-network provider, or when you have utilized an in-network site or provider from an in-network provider.

Subscriber Information (Please print clearly)

Subscriber Name	First Name	Last Name	Employer Name
Mailing Address	City	State	ZIP
Subscriber ID Number	Name of Employer		

Patient Information

Patient Name	Date of Birth	Authorization Number	POB Time Stamp
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Claim Information

Class of Service	Single Vision Contact	Contact
Exam	Multiple Vision Contact	Contact with Fitting Exam
Other	Program Extension	Other

Is the provider an in-network provider? Yes No
 Provider Name: _____ Phone Number: _____

If you saw an in-network provider:
 Are you seeking for reimbursement after getting an invoice with a date of service?
 Yes No

If you saw an in-network provider but chosen to take advantage of a date, receipt, or other in-network benefit, the provider may require that you pay in full and then submit your receipt for Superior Vision for reimbursement at the out-of-network rates.

If you have a date, receipt, or other in-network benefit at the time of your visit, you are also responsible for paying for any services or materials that are not covered or that exceed your benefit plan coverage. If you paid in full for the services, please provide a self-statement on why your provider did not bill on your behalf.

Mail or fax a copy of the completed invoice or receipt approved with the provider's report and address along with this form to the contact information below. Please retain the original for your records.

Superior Vision
 Attn: Claims Processing
 P.O. Box 967
 Rancho Conejo, CA 91741
 Fax: (818) 852-2277

Questions? Please call our Customer Service department at (800) 507-3800

Have any questions? Give us a call.

Contact us with any questions at **1 (800) 243-1401**. We are available Monday - Friday, 9AM - 6PM (EST).