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Policy Number
☐ ChoicePlus POS #714569
☐ Options PPO #716450
☐ Select EPO #716451

Maryland State Employees/Retirees Routine Vision Service Form

Section 1 Patient Information

Member Number	Employee's Name (Last) (First) (M.I.)
Patient's Name (Last) (First) (M.I.)	Employee Address
Patient's Address (if Different than Employee's)	**Patient's Relationship to Employee** o Self o Spouse o Dependent Child o Other **Patient's Sex** o Male o Female
	Telephone Numbers Home Work
	Patient's Birthday

Section 2 Physician/Health Care Practitioner Information

Name (PLEASE PRINT) Tax ID Number ☐☐☐☐☐☐☐☐☐

Address Street City State ZIP Code

Practitioner must complete information below where applicable:

Line#	Date of Service Mo	Day	Yr	Proc Code	Description of Service (Available one a year)	Charges
1					Exam (Vision Analysis)	
2					Frames (Per Frame)	
3					Lenses, Single Vision	
4					Lenses, Bifocal Single	
5					Lenses, Bifocal Double	
6					Lenses, Trifocal	
7					Lenses, Aphakic (Glass)	
8					Lenses, Aphakic (Plastic)	
9					Lenses, Aphakic (Aspheric)	
10					Contact Lenses (Cosmetic)	
11					Contact Lenses (Medically Required*	

Diagnosis_____
*Complete below if Contact Lenses are medically required:
Date of Cataract Surgery_____
Visual Acuity before_____after_____lenses.
Would glasses correct Visual Acuity to at least 20/70 in the better eye? o Yes o No

Total Charges:_____

Practitioner Signature Date

Section 3 Assignment of Benefits(if signed, payment will be made directly to practitioner)

I hereby authorize payment directly to the provider of services. I understand that I am financially responsible to the provider for charges not covered by this assignment.

Signed _____ Date _____

Section 4 Authorization

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Subscriber, am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.
Subscriber Signature _____ Date _____ Daytime Telephone _____
(Receipt must be attached for reimbursement)

Employee Address Correction
_____
_____
_____

Vision Form Instructions

This Vision Service Form must be accompanied by a receipt if paid by the member. This form must be used by you to file a claim for reimbursement or, if your provider accepts Assignment of Benefits, to assign your benefits to the provider. NOTE: Claims must be submitted within one year from date of service. Claims received after that period will be denied. Additionally, claims will be denied if you are found to be ineligible.

Section 1: Patient information

This section contains information which identifies the person who is eligible to receive services.

1. Complete each block.
2. Indicate the Member Number of the patient.
3. Complete employee information.

Section 2: Physician/health care practitioner information

The provider (eye doctor or optician) must complete this section.

1. Column 1: Enter the month/day/year that the service was provided.
2. Column 2: Enter amount charged for the service.
3. Complete the remaining provider information requested (if applicable).
4. If you (physician or health care practitioner) are to receive payment, the State of Maryland employee will sign the Assignment of Benefit section.
5. Be certain that all necessary patient and provider information has been completed.

Section 3: Assignment of benefits (if applicable)

If signed, payment will be made directly to physician or health care practitioner. The member will be reimbursed only if acceptable proof of payment is submitted with claim. Acceptable proof of payment includes cancelled check or receipt from the provider of service.

Section 4: Authorization

Your signature indicates agreement with the written authorization in this section and certifies that the services as described were received by you or your dependent. Indicate date signed and daytime telephone number.

Mailing instructions (employee/physician or health care practitioner)

Mail the completed Service Form and a copy of the receipt to:

UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800

Submitting an incomplete form will result in a delay in processing.

For questions, call the dedicated State of Maryland Member Services at 1-800-382-7513.