

Out-Of-Network Vision Claim Form

Date of Service: _____

Group Name: _____

Subscriber Name: _____

Subscriber ID: _____

Subscriber Date of Birth: _____

Patient Name: _____

Patient Date of Birth: _____

Please provide the subscriber's current mailing address:

Please place an "X" in the box next to each service you received, and include the dollar amount you were charged for the service.

- Exam \$ _____
- Fitting of Contacts \$ _____
- Contacts \$ _____
- Single Vision Lenses \$ _____
- Bifocal Lenses \$ _____
- Trifocal/Progressive Lenses \$ _____
- Frame \$ _____

Please complete and sign this form. Copies of your itemized receipts must be included.
 If you need help in filling out this form, please contact Customer Care at (800) 865-3676.

I authorize the release of records to process this claim.

Signed _____

Date _____

Submit claims to CompBenefits, Attn: Non-Panel Claims, P O Box 14311 Lexington, KY 40512-4311