

**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.**

- |                          |                             |          |
|--------------------------|-----------------------------|----------|
| <input type="checkbox"/> | Exam                        | \$ _____ |
| <input type="checkbox"/> | Fitting of Contacts         | \$ _____ |
| <input type="checkbox"/> | Contacts                    | \$ _____ |
| <input type="checkbox"/> | Single Vision Lenses        | \$ _____ |
| <input type="checkbox"/> | Bifocal Lenses              | \$ _____ |
| <input type="checkbox"/> | Trifocal/Progressive Lenses | \$ _____ |
| <input type="checkbox"/> | 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 23328, Tampa, FL 33630-3349**