# Out-of-Network Reimbursement if not able to use In-Network Provider

**Use this form to request reimbursement for your out-of-network claim using your in-network benefits. One of the following exceptions must apply:**

**Based from your home or work (office) location, you were unable to:**

1. **Locate an in-network provider within a reasonable distance, considering whether you live in an urban, suburban or rural area;**
2. **Schedule a visit with an in-network provider within two-weeks; or**
3. **Access an in-network provider during a declared emergency in the state where you live.**

**If one of the three exceptions above applies to you, you may complete this form on-line.**

**By mail, you can print, complete and sign this claim form. If you are a Medicare member, you may use this form or just submit a written request with all information that would be on the form. The mailing address is:**

**First American Administrators, Inc.**
Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111

**Caution, this option is not available when you choose to use an out-of-network provider due to:**

1. Your preference;
2. When your personal schedule does not permit you to schedule an appointment with an available provider in two-weeks; or
3. You are outside of your home or work (office) location for anything other than a declared emergency.

NOTE: Any person who submits a request or files a claim containing a false or deceptive statement, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, is guilty of insurance fraud.

**Check only one reason that applies. If you fail to provide the requested information for your selection, you may not qualify for an exception to the requirement to use network providers:**

☐ I was unable to locate an in-network provider within a reasonable distance. I live or work in the following zip code:

Zip Code

I believe my area is:

☐ Urban ☐ Suburban ☐ Rural

## OR ----------

☐ I was unable to schedule a visit with an in-network provider within two weeks.

Please provide the in-network provider's name, address and phone number who could not provide an appointment within two weeks:

Provider's Name

Provider Telephone Number
(000) 000-0000

Provider Street Address

City

State

Zip Code

## OR ----------

☐ I was unable to find an in-network provider during a state of emergency impacting my area. Please provide the zip code of the emergency and approximate date the state of emergency was declared:

Zip Code

Month/Year of the Declared Emergency

*continued*

## CLAIM FORM 2: EXCEPTION REQUEST

Patient Last Name† | Patient First Name† | MI

Birth Date (MM/DD/YYYY)† | Street Address†

City† | State† | Zip Code†

Patient Member ID # | Relationship to Subscriber†

Self ◯ Dependent ◯

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Subscriber Last Name† | Subscriber First Name† | MI

Birth Date (MM/DD/YYYY)† | Street Address†

City† | State† | Zip Code†

Vision Plan Name | Date of Service† (MM/DD/YYYY)

Vision Plan Group # | Subscriber Member ID #

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Doctor or store where patient received services

Provider's Name† | Provider's NPI

Provider Street Address†

City† | State† | Zip Code†

†Required

*continued*

# Request for Reimbursement

Enter Amount Charged.† Remember to include itemized paid receipts.†

| Service Type | Amount Charged | Lens Type | Please Check | Lens Options: (if purchased) | Amount Charged |
|---|---|---|---|---|---|
| Exam *92014* | $ | Single *V2100* | ☐ | Anti-Reflective *V2750* | $ |
| Refraction *92015* | $ | Bifocal ***V2200*** | ☐ | Polycarbonate ***V2784*** | $ |
| Frame *V2025* | $ | Trifocal *V2300* | ☐ | Scratch *V2760* | $ |
| Contact Lens *S0500* | $ | Progressive ***V2781*** | ☐ | Tint *V2745* | $ |
| Contact Lens Fitting *92310* | $ | Prem Prog *V278126* | ☐ | UV *V2755* | $ |
| Lenses | $ | Other | $ | Roll and Polish *V2702* | $ |

Enter Total Amount Paid as shown on receipt, excluding sales tax† $

I certify that I have read the state fraud warnings. If I want a printed copy, I can contact the customer call center. I understand that I may be denied reimbursement if I am not eligible for out-of-network benefits or if I do not supply the requested information for the claim. I authorize any insurance company, organization employer, ophthalmologist, optometrist and optician to release any information with respect to this claim. I agree with all statements above and certify all of the information furnished on this form is true and correct.

Member/Guardian/Patient Signature (not a minor)† Date

†Required