

# UnitedHealthcare Vision

## VISION PLAN OUT OF NETWORK CLAIM

Today's Date		Date of Service	
Employee's Name		Employee's Unique Identification Number	
Address Where Check Should Be Mailed (Address, City, State, Zip Code)			
Patient's Name		Patient's Relationship to Employee	Patient's Date of Birth
Employee Signature			Date

**RETURN THIS FORM WITH A COPY OF YOUR PAID, ITEMIZED RECEIPT TO:**

**UnitedHealthcare Vision  
ATTN: Claims Department  
PO Box 30978  
Salt Lake City, UT 84130**

**FAX: (248) 733-6060**

If you have any questions on your vision coverage, please call our  
Customer Service Department at (800) 638-3120.  
Please have the employee's unique identification number ready.