VISION CLAIM TRANSMITTAL

**Please remember to include a copy of your receipt with this claim form – Thank you!

Please forward completed form along with bill or receipt to:
UnitedHealthcare
Attn: Field Account Manager – WI105-0401
3100 AMS Blvd.
Green Bay, WI 54307
Fax: 1-866-894-3735
Customer Service: 1-800-549-9226

Employer Name: **Racine County** Group (Policy) Number: **712930**

Vision Care Providers – please make sure you have indicated the patient's diagnosis, date of service, and circled the appropriate procedure codes in Section D prior to submitting this claim.

A. MEMBER/EMPLOYEE INFORMATION (Please include your member ID on all documentation):

Member # (SSN)	Last Name:	First Name:	MI:
Home Address	City	State	Zip Code:

B. PATIENT INFORMATION:

Last Name:	First Name:	MI:	Date of Birth:
Sex M ☐ F ☐	Relationship to Member:	Full Time Student Yes ☐ No ☐	School Name:

C. PLACE OF SERVICE: 11 / OFFICE

D.THIS SECTION TO BE COMPLETED BY PROVIDER
PLEASE CHECK APPROPRIATE BOXES AND INDICATE APPLICABLE CHARGES:

Exams

Diagnosis: Z01.00

Date of Exam: _____

New Patient	☐ 92002	$_____
	☐ 92004	$_____
Established Patient	☐ 92012	$_____
	☐ 92014	$_____
Refraction	☐ 92015	$_____
	☐ 92310	$_____

Lenses

Date of Purchase:_____

Single Vision	☐ V2101	$_____
Bifocals	☐ V2200	$_____
Trifocals	☐ V2300	$_____
Progressive	☐ V2781	$_____

Frames

Date of Purchase: _____

Standard	☐ V2020	$_____
Deluxe	☐ V2025	$_____

Contact Lenses

Date of Purchase:_____

PMMA	☐ V2500	$_____
Gas Permeable	☐ V2510	$_____
Hydrophilic	☐ V2520	$_____
Scleral	☐ V2530	$_____

Description:	
Total Charges $	Amount Paid by the Employee $
Name of Provider who Performed the Services:	Phone (Area Code):
Address:	City-State-Zip Code:
Provider's Signature:	**Tax ID #:** _____
Date: / Degree/Title:	**Tax ID # is required or claim will NOT be paid**

Must be Furnished Under Authority of Law

E. AUTHORIZATION

Note: Payment will be made directly to the employee. Employee is responsible for reimbursing provider if necessary.

Patient Signature:	Member Signature:	Date:

NOTE: Make sure that the form is completely filled out and attach a copy of bill or receipt. Return form, along with bill or receipt, to address located in upper right hand corner or FAX information to 1-877-881-2325.

(Rev. 4/2016)