



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 on your home or work address:

Based from your home or office location, you were unable to:

- (i) Locate a participating provider within a 10-mile radius in an urban-suburban area,
- (ii) Locate a participating provider within a 20-mile radius in a rural area, or
- (iii) Schedule a visit within two-weeks.

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.

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:

- (i) your preference,
- (ii) when your personal schedule does not permit you to schedule an appointment with an available provider in two-weeks, or
- (iii) you are outside of your home or office location.

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

CLAIM FORM 2: EXCEPTION REQUEST, NO OUT-OF-NETWORK BENEFIT

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

I was unable to locate a participating provider within a 10-mile radius in an urban-suburban area.

Please provide the zip code in which you were attempting to locate a provider:

Zip Code

OR

I was unable to locate a participating provider within a 20-mile radius in a rural area.

Please provide the zip code in which you were attempting to locate a provider:

Zip Code

OR

I was unable to schedule a visit within two-weeks with a participating provider.

Please provide the In-Network provider's name, address and phone number for whom you tried to schedule an appointment:

Provider's Name

Provider Telephone Number
(000-000-0000)

Provider Street Address

City

State

Zip Code

CLAIM FORM 2: EXCEPTION REQUEST, NO OUT-OF-NETWORK BENEFIT

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

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 #

Doctor or Store where patient received services

Provider's Name† Provider's NPI

Provider Street Address†

City† State† Zip Code†

†Required

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*	\$ <input type="text"/>
Refraction *92015*	\$	Bifocal *V2200*		Polycarbonate *V2784*	\$ <input type="text"/>
Frame *V2025*	\$	Trifocal *V2300*		Scratch *V2760*	\$ <input type="text"/>
Contact Lens *S0500*	\$	Progressive *V2781*		Tint *V2745*	\$ <input type="text"/>
Contact Lens Fitting *92310*	\$	Prem Prog *V278126*		UV *V2755*	\$ <input type="text"/>
Lenses	\$	Other	\$	Roll and Polish *V2702*	\$ <input type="text"/>

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