UnitedHealthcare Vision℠

Vision Plan
Reimbursment Claim Form

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
P.O. 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.