UnitedHealthcare
Oxford

Vision Plan
Claim Reimbursement Form

Today's Date	Date of Service
Member Last Name, First Name	Member ID#

Address (Address, City, State, Zip code)

Parent/ Responsible Party's Name (only applies for patients under 18)

Member or Responsible Party's Signature _____ Date _____

RETURN THIS FORM WITH A COPY OF YOUR PROVIDER'S BILL AND ITEMIZED PAID RECEIPT OR PROOF OF PAYMENT TO:

UnitedHealthcare
Attn: Claims Department
PO Box 29130
Hot Springs, AR 71903

If you have any questions on your vision coverage, please call our Customer Service Department at 1-800-385-9055. Please have your Member Identification number ready.