

# Out-of-Network Claims if you have Out-of-Network Benefits

**Use this form if you receive vision services from an out-of-network eyecare provider and you have out-of-network benefits. If your plan does not include out-of-network benefits, please see the Network Exceptions form, claim form 2, for separate processing instructions.**

To request reimbursement, please complete and sign the itemized claim form. Return the completed form and your itemized paid receipts to:

Cigna Healthcare Claims Department  
c/o First American Administrators, Inc.  
Attn: OON Claims, PO Box 8504, Mason, OH 45040-7111

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<b>Patient Last Name<sup>†</sup></b>	<b>Patient First Name<sup>†</sup></b>	<b>MI</b>
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<b>Birth Date (MM/DD/YYYY)<sup>†</sup></b>	<b>Street Address<sup>†</sup></b>
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<b>City<sup>†</sup></b>	<b>State<sup>†</sup></b>	<b>Zip Code<sup>†</sup></b>
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<b>Patient Customer ID #</b>	<b>Relationship to Subscriber<sup>†</sup></b>
	Self      Dependent

<sup>†</sup>Required

CLAIM FORM 1: REIMBURSEMENT FOR OUT-OF-NETWORK BENEFIT

Subscriber Last Name <sup>†</sup>		Subscriber First Name <sup>†</sup>		MI
Birth Date (MM/DD/YYYY) <sup>†</sup>		Street Address <sup>†</sup>		
City <sup>†</sup>		State <sup>†</sup>	Zip Code <sup>†</sup>	
Vision Plan Name		Date of Service <sup>†</sup> (MM/DD/YYYY)		
Cigna Healthcare				
Vision Plan Group #		Subscriber Customer ID #		

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Provider or Retailer where patient received services

Provider's Name <sup>†</sup>		Provider's NPI	
Provider Street Address <sup>†</sup>			
City <sup>†</sup>		State <sup>†</sup>	Zip Code <sup>†</sup>

<sup>†</sup>Required

**CLAIM FORM 1: REIMBURSEMENT FOR OUT-OF-NETWORK BENEFIT**

# Request for Reimbursement

**Enter Amount Charged.<sup>†</sup> Remember to include itemized paid receipts.<sup>†</sup>**

<b>Service Type</b>	<b>Amount Charged</b>	<b>Lens Type</b>	<b>Please Check</b>	<b>Lens Options: (if purchased)</b>	<b>Amount Charged</b>
<b>Exam</b> *92014*	\$	<b>Single</b> *V2100*		<b>Anti-Reflective</b> *V2750*	\$ <input type="text"/>
<b>Refraction</b> *92015*	\$	<b>Bifocal</b> *V2200*		<b>Polycarbonate</b> *V2784*	\$ <input type="text"/>
<b>Frame</b> *V2025*	\$	<b>Trifocal</b> *V2300*		<b>Scratch</b> *V2760*	\$ <input type="text"/>
<b>Contact Lens</b> *S0500*	\$	<b>Progressive</b> *V2781*		<b>Tint</b> *V2745*	\$ <input type="text"/>
<b>Contact Lens</b> Fitting *92310*	\$	<b>Prem Prog</b> *V278126*		<b>UV</b> *V2755*	\$ <input type="text"/>
<b>Lenses</b>	\$	<b>Other</b>	\$	<b>Roll and Polish</b> *V2702*	\$ <input type="text"/>

**Enter Total Amount Paid as shown on receipt, excluding sales tax<sup>†</sup>**

\$

I certify that I have read the [state fraud warnings](#). If I want a printed copy, I can contact the customer call center at 1.888.353.2653. 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.

**Customer/Guardian/Patient Signature (not a minor)<sup>†</sup>**

**Date**

<sup>†</sup>Required