*Vision*Care Benefit

Member Reimbursement Form

Instructions

1. Please use this ***Vision*Care** benefit member reimbursement form to request reimbursement for the V*ision*Care benefit only. For other eyewear coverage that may be available due to a medical condition (post-cataract or retinal detachment surgery or Keratoconus), please refer to "Special Conditions" on the other side of this form.
2. Please read and complete this form.
3. Attach **proof of payment** and an itemized bill from the provider which includes the date of service, description of services provided, provider's tax ID number and amount paid.
4. Mail the original form, together with the bill and proof of payment to:

   HPHC Claims
   P.O. Box 699183
   Quincy, MA 02269-9183.

Member Information

Subscriber Name: First _____ Middle Initial _____ Last _____

Address _____ City _____ State _____ Zip _____

Patient's Name: First _____ Middle Initial _____ Last _____

Patient's Identification No. (from ID card) _____ Date of Birth _____ Sex (m/f) _____

Claim Information

Check (√) item that applies	Description of Services	Procedure No.	No. of Services	Place of Service	Date(s) of Services Rendered	Amount Billed
	eyeglass frames or lenses	92390	1	11		
	contact lens services (including fitting)	92310	1	11		

Diagnosis

Z01.01 - routine vision correction ❑ yes ❑ no If no, please see other side for "special conditions" section	TOTAL DUE MEMBER $

Provider Information

Name of Provider _____

Address _____ City _____ State _____ Zip _____

Mail to: HPHC Claims • P.O. Box 699183 • Quincy, MA 02269-9183 • 1-888-333-4742

Special Conditions

For certain medical conditions, such as Keratoconus, post-retinal detachment surgery or post-cataract surgery, eyewear benefits may be available. Please refer to your Member Agreement for details. If you have a claim for eyeglasses or contact lenses for special conditions that are covered under the medical benefit please do the following:

1. Have your optical provider complete a standard claim form and submit the claim for processing. **Do not use the *Vision*Care benefit member reimbursement form to request initial payment for eyewear obtained due to these conditions.**
2. If there is a remaining balance due to the provider after Harvard Pilgrim pays the claim, use this *Vision*Care benefit member reimbursement form to request reimbursement for the balance due under your *Vision*Care benefit (up to the benefit limit). Attach a copy of the itemized bill from your optical provider that includes:
    - original dollar amount of services provided;
    - the appropriate diagnostic code(s):
        - Post-cataract surgery (H26.40, H26.411-H26.419, H26.491-H26.499, H26.8, H26.9, Z96.1)
        - Post-retinal detachment surgery (H52.31, Z98.41-Z98.49)
        - Keratoconus (H18.601-H18.609, H18.611-H18.619, H18.621-H18.629)
    - amount of Harvard Pilgrim payment;
    - amount you still owe to provider after Harvard Pilgrim payment.

Assignment of Benefits

PAYMENT WILL BE MADE DIRECTLY TO YOU, IF YOU SIGN BELOW.

I authorize reimbursement of benefits to myself for the services described above or as indicated on the enclosed bill. I understand that I am financially responsible to the provider for charges in excess of the Plan's schedule or charges not covered by my benefit plan.

Subscriber's Signature _____ Date _____

I hereby apply for benefits and certify that the above information is complete, true and correct. To all physicians and other medical professionals, hospitals, and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators: You are authorized to provide the Plan and any benefit plan administrators from consumer reporting agencies, attorneys and independent claim administrators acting on the Plan's behalf, with information concerning medical care, advice, treatment or supplies to the Patient, and any employment-related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

CLAIM CANNOT BE PROCESSED WITHOUT SUBSCRIBER'S SIGNATURE

_____ _____

Subscriber's Signature Date Dependent Patient's Signature Date

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللغة **العربية** ، خدمات المساعدة اللغوية متوفرة لك مجانا. **إتصل على 1 888-333-4742** (TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી **(Gujarati)** ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

(Continued)

General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.