Harvard Pilgrim Health Care

# Pediatric VisionCare - Connecticut

If your plan includes this benefit, dependents under the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. Each Dependent under the age of 19 is eligible for coverage every Plan Year for *either* (A) prescription eyeglass frames and lenses or (B) prescription contact lenses, as described below.

**(A) Prescription Eyeglass Frames and Lenses**
One pair of Standard or Basic prescription eyeglass frames and lenses. Standard or basic lenses are limited to glass or plastic single vision lenses, conventional bifocal lenses, conventional trifocal lenses and lenticular lenses.

**(B) Prescription Contact Lenses**
Your first order of prescription contact lenses. Reimbursement for disposable contact lenses is limited to a 6 month supply.

## How to Receive Reimbursement for the Pediatric Vision Care Benefit

To receive reimbursement for prescription eyeglasses and frames or prescription contact lenses that you have paid for, complete the Pediatric VisionCare member reimbursement form below.

The Plan will reimburse you for your payment of covered items as described above. The reimbursement is applied AFTER application of discounts, coupons or other offers. Please allow 6-8 weeks to receive your reimbursement.

## Where to Call With Questions

If you have any questions about your Pediatric VisionCare, please contact Member Services at **(888) 333-4742.** If you are deaf or hard-of-hearing, call **711** for TTY service.



cc4958_ct 5_17

# Pediatric Vision Benefit Member Reimbursement Form

## Instructions

1. Please use this benefit member reimbursement form to request reimbursement for the Pediatric Vision benefit only.
2. Please read and complete this form. Separate forms must be completed for each member seeking Pediatric Vision benefits.
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 lenses | 92310 | 1 | 11 | | |
| | Scratch resistant coating, per lens | V2760 | 1 | 11 | | |
| | Progressive Lens, per lens | V2781 | 1 | 11 | | |

## Diagnosis

ICD-10 Z01.00-Z01.01 routine vision correction ❑ yes ❑ no

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**

## 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 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 | Patient's Signature | Date |