blue california

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

Use this form if you receive vision services from an out-of-network eye doctor 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.

If you are a Medicare member, you may use this form or just submit a written request with all information that would be on the form.

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

First American Administrators, Inc.
Attn: OON Claims, PO Box 8504, Mason, OH 45040-7111

Patient Last Name†

Patient First Name†

MI

Birth Date (MM/DD/YYYY)†

Street Address†

City†

State†

Zip Code†

Patient Member ID #

Relationship to Subscriber†

Self ◯ Dependent ◯

†Required

Subscriber Last Name† | Subscriber First Name† | MI

Birth Date (MM/DD/YYYY)† | Street Address†

City† | State† | Zip Code†

Vision Plan Name | Date of Service† (MM/DD/YYYY)

Vision Plan Group # | Subscriber Member ID #

Doctor or Store where patient received services

Provider's Name† | Provider's NPI

Provider Street Address†

City† | State† | Zip Code†

†Required

Request for Reimbursement

Enter Amount Charged.† Remember to include itemized paid receipts.†

Service Type	Amount Charged
Exam *92014*	$
Refraction *92015*	$
Frame *V2025*	$
Contact Lens *S0500*	$
Contact Lens Fitting *92310*	$
Lenses	$

Lens Type	Please Check
Single	☐
Bifocal	☐
Trifocal	☐
Progressive	☐
Prem Prog	☐
Other	$

Lens Options: (if purchased)	Amount Charged
Anti-Reflective *V2750*	$
Polycarbonate *V2784*	$
Scratch *V2760*	$
Tint *V2745*	$
UV *V2755*	$
Roll and Polish *V2702*	$

Enter Total Amount Paid as shown on receipt, excluding sales tax† $

If I want a printed copy, I can contact the customer call center. 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. For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Member/Guardian/Patient Signature (not a minor)† Date

†Required