UnitedHealthcare Vision℠

Duke University
Out of Network Claim Form

Today's Date	Date of Service

Employee's Name	Employee's Vision Identification Number* (an eight digit number)

Address where the check should be mailed (address, city, state, zip code)

Patient's Name	Patient's Relationship to Employee	Patient's Birthdate

_____ _____

Employee Signature Date

RETURN THIS FORM WITH A COPY OF YOUR PAID, ITEMIZED RECEIPT TO:
(Note: This itemized receipt should include a description of the services provided.)

UnitedHealthcare Vision
ATTN: Claims Department
PO Box 30978
Salt Lake City, UT 84130

Fax: 248-733-6060

If you have any questions on your vision coverage, please call UnitedHealthcare Vision's Customer Service Department at (800) 638-3120.

*The employee's vision identification number is their Duke Unique ID number plus a leading zero for a total of an eight digit number.