MetLife
Metropolitan Life Insurance Company

METLIFE VISION MEMBER REIMBURSEMENT FORM

To request reimbursement, complete and print this form, enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.

MetLife Vision
PO Box 495918
Cincinnati, OH 45249-5918

PATIENT

Relation to Member*: *(choose one)*
- ○ Member
- ○ Domestic Partner
- ○ Dependent Parent
- ○ Disabled Dependent
- ○ Spouse
- ○ Child
- ○ Full-Time Student
- ○ Other

Date of Birth*: *(mm/dd/yyyy)*		Gender*:	○ Male ○ Female				
Last Name*:		First Name*:		MI:			
Address*:							
City*:		State*:		ZIP Code*:		ZIP+4:	

MEMBER

Last 4 Digits of SSN*:							
☐ Member information below is the same as Patient							
Date of Birth*: *(mm/dd/yyyy)*		Gender*:	○ Male ○ Female				
Last Name*:		First Name*:		MI:			
Address 1*:		Address 2:					
City*:		State*:		ZIP Code*:		ZIP+4:	

CLAIM

Date of Service*: *(mm/dd/yyyy)*		☐ Another insurance company made payments to you, another insurer, or the doctor's office. If so, attach a copy of the statement showing payment.

Exam.. $
Frame.. $
Lens.. $
Lens tints or coatings.................................... $
Contact Lens Exam / Fitting Evaluation........... $
Contacts.. $

Lens Type*: *(choose one)*
- ○ Single
- ○ Progressive
- ○ Bi-focal
- ○ Lenticular
- ○ Tri-focal

PROVIDER

Last Name:		First Name:					
Office Name:							
Address 1*:		Address 2:					
City*:		State*:		ZIP Code*:		ZIP+4:	

PRINT & SIGN

By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information I have provided above is true and complete to the best of my knowledge. I acknowledge that the above-named provider is not a MetLife In-Network Vision Provider and that MetLife Vision cannot guarantee my eye care and/or eyewear satisfaction.

New York residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant Signature: ______________________________ Date: ______________

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