VISION HARDWARE REIMBURSEMENT PROGRAM

In order to process your request for vision reimbursements in a timely manner, **Paramount must receive specific information for claims processing**. Incomplete information will delay processing of your reimbursement check. A description of reimbursement coverage is provided in your *Summary of Benefits* and *Evidence of Coverage* member handbooks. Please follow the step-by-step instructions for all required fields to ensure your vision hardware reimbursement can be processed promptly. Thank you.

Should you have any questions regarding the
vision reimbursement program, please contact:
Paramount's Member Services Department
Telephone: 419-887-2525 or 1-800-462-3589 (toll-free)
TTY for Hearing Impaired: 1-888-740-5670 (toll-free)
Or visit our web site at *www.paramounthealthcare.com.*

Not Acceptable –

YOU WILL RECEIVE DENIAL FOR ADDITIONAL INFORMATION FOR:

- Handwritten payment on statement/bill without proof of payment included.
- Previous balance statements with no itemization charges.

Cataract Hardware –

- Glasses after cataract surgery will be covered under your medical benefit first. Your remaining balance may be submitted under your vision hardware reimbursement program for consideration up to your benefit limits.

Please ask your provider to assist you in completing Section II of the attached claim form. Submit completed forms to the address provided.

Thank You

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I. MEMBER INFORMATION AND SIGNATURE

By submitting this claim form, I (participant named below) request reimbursement from Paramount as listed below. I certify that these are eligible expenses I have incurred and have attached proof of payment. Please pay me directly.

Member Name ______________________________ ID # ______________

Address ______________________________

City/State ______________________________ Zip ______________

Signature ______________________________ Date ______________

Do you have another vision policy? Yes ______ No ______

If yes, please attach a copy of your other policy's **Explanation of Benefits** which shows the amount they have paid for the same services. You can only receive a reimbursement for covered services that have not been paid for by another policy.

FOR PROVIDER USE ONLY:

The below information must be completed to ensure accuracy and timely payment to the provider.

II. DESCRIPTION OF VISION HARDWARE SERVICES ONLY

Date of Service	Procedure Code	Description of Services	Billed Amount

Provider Certification/Verification –

I certify that the patient named above incurred these expenses.

Provider Name ______________________ Provider # ____________ ____________

Address ______________________ City ____________ State ______ Zip ________

Check Where Applicable: Reimburse Provider ________ Reimburse Member ________

Provider Signature ______________________________ Date ______________

Please mail your reimbursement request to:

Reimbursement Processing
P.O. Box 928
Toledo, OH 43697-0928