In-Network Request for Reimbursement for Vision benefits

Process & Requirements

Are you eligible for reimbursement?

You may be eligible for in-network reimbursement depending on these situations:

Eligibility Issue

- Your information is not loaded into the system or needs to be updated
- You temporarily lost coverage and paid out-of-pocket at a new in-network provider

System Issue

- Our Provider Portal is down
- Your provider could not verify eligibility/benefits at the time of service

In-network Provider Problem

- Your provider refuses to file the claim
- Your provider refuses to use required lab
- You purchased a designer frame

What information do I need to submit for reimbursement?

In order to process your request for reimbursement, you must provide a paid, itemized receipt.

The paid, itemized receipt must show:

- Patient Name
- Date of Service
- Provider Name and/or location of service
- Individual Service(s)
- Fee for each service
- Service(s) paid in full/ $0 balance
- Proof of payment

Note: Credit card/register receipts require a fully itemized receipt.

Itemized services must show:

- All services must be itemized to show individual service and fees for each service received (ex: Bifocal, Trifocal, V2200, V2781, brand of progressive, lens options, exam fee, CL fit fee, brand of contacts, individual fees for lens options, etc.)

What situations do not qualify for reimbursement?

You will not be eligible for in-network reimbursement for if either of these scenarios applies:

- In-network reimbursement DOES NOT APPLY if you receive a discount, buy one get one (BOGO) promotion, store sale, etc. You may either take advantage of the store promotion or use your vision plan benefits, but not both.
- In-network reimbursement DOES NOT APPLY if you did not give your vision insurance information, did not give the correct vision insurance information, used other insurance first and/or gave medical insurance.

How do I submit my itemized receipts for reimbursement?

Please **fax or mail** the paid itemized receipt and include:

- Member ID#
- Policy Holder Name
- Patient Date of Birth
- Home Address

You may also use the attached form to provide member information. The paid itemized receipt and member information can be submitted by

Faxing to:

877-410-2517
Attn: In-Network Reimbursements

or mailing to:

Vision Customer Advocate Team
KelseyCare Advantage In-Network Reimbursements
19500 W Interstate 10
Building 2
San Antonio TX 78254

Timeframe: Your reimbursement request (claim) will be processed within 30 days from the date the claim is received. Credit card and/or register receipts require a fully itemized receipt.

Questions? Please call our Customer Service Department at (877) 574-7081 (711).

Call Member Services at 713-442-2273 (TTY: 711). From October 1 through March 31, hours are 8 a.m. to 8 p.m., seven days a week. From April 1 through September 30, hours are 8 a.m. to 8 p.m., Monday through Friday. Messaging services are used on weekends, after hours, and on federal holidays. KelseyCare Advantage is an HMO and POS with a Medicare contract. Enrollment in KelseyCare Advantage depends on contract renewal.

KelseyCare Advantage

Vision Plan In-Network Reimbursement Form

Please complete the member information below.

Today's Date:	Date of Service:
Member Name:	Member ID#:
Member Date of Birth:	Provider:

Address where check should be mailed:

Address

City State ZIP

Please complete services and materials received. You must provide the costs paid. Costs paid must match submitted receipt(s).

Please Note: Receipts must be submitted together at the same time for services and materials purchased (even if purchased on different dates) to receive reimbursement. You will receive a one-time reimbursement based on your service frequency in your vision care plan.

Exam

☐ Eye / Vision Exam Paid: $

Complete below for glasses OR...		Complete below for contacts	
Glasses		**Contacts**	
☐ Frames	Paid: $	☐ Contact Fitting / Exam	Paid: $
Glasses Lens Type (Check only one)		☐ Contact Lenses	Paid: $
☐ Single-vision lenses	Paid: $	Note: Contact fitting fees must accompany contact lenses purchased.	
☐ Bi-focal lenses	Paid: $		
☐ Tri-focal lenses	Paid: $		
☐ Lenticular lenses	Paid: $		
Member Signature:		Date:	

Please return this form with a copy of your paid, itemized receipt and proof of payment to:

Vision Customer Advocate Team
KelseyCare Advantage In-Network Reimbursements
19500 W Interstate 10
Building 2
San Antonio, TX 78254
Fax: Attn - In-Network Reimbursements (877) 410-2517

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WARNING: Any person who knowingly files a statement of claim containing any misrepresentations or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.