Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

1800 Ninth Avenue
PO Box 91015
Seattle, WA 98111-9115

Uniform Medical Plan

VISION CLAIM FORM

Use this form to submit reimbursement requests for services from a non-network provider or for the purchase of prescription contact lenses or eyeglasses. Please complete a separate form for each family member. The time limit for filing claims is one year from the date of service/purchase.

Note: This form may be used for claims for PEBB Uniform Medical Plans. Most providers will bill directly and no claim form will be necessary. However, if you do incur expenses from a provider that does not bill the plan directly, you will need to complete sections 1, 2 and 5 of the claim form. Have your provider complete sections 3 and 4 (Physician or Supplier information) unless the itemized bill(s) include this information.

1. Complete the information below and on the back of this form.
2. Attach itemized bills, including patient's name, date of service, diagnosis, procedures and charges.
3. Retain copies for your records. Receipts will not be returned.
4. Sign the completed form where indicated at the bottom of this page and submit the completed claim form to:

   Regence BlueShield
   Attn: UMP Claims
   PO Box 1106
   Lewiston, ID 83501-1106
   Or by fax to: 1-877-357-3418

Payments will be mailed to the address on file for the subscriber. You can verify your address by calling PEBB UMP Customer Service at 1 (888) 849-3681.

1. EMPLOYEE/RETIREE INFORMATION			**2. PATIENT INFORMATION**	
UMP Identification Number (include alpha characters)				
Patient's Last Name			Patient's First Name	MI
Patient's Date of Birth	Patient's Sex ☐ Male ☐ Female	Patient's Relationship to Subscriber ☐ Self ☐ Spouse OR certified domestic partner (DP) ☐ Dependent		Daytime Phone Number
Subscriber's Last Name			Subscriber's First Name	MI
Group Name **Uniform Medical Plan**			Group Number	

3. EXAMINING PHYSICIAN OR OPTOMETRIST INFORMATION			
UMP Identification Number (include alpha characters)			
Date of Service	Services Rendered	Refraction Included? ☐ Yes ☐ No	Charge
Physician's or Optometrist's Name, Address and ZIP code	Diagnosis code	Procedure code	
	Telephone Number		
Signature of Physician or Optometrist ▶	Date Signed		

- Continued on reverse -

4. SUPPLIER INFORMATION (To be completed by provider or attach a copy of the prescription)

All sections must be fully completed before this claim will be processed or attach a copy of the prescription.

Lenses for ☐ One Eye ☐ Both Eyes	Date Ordered	Date Delivered

Glasses: ☐ One Pair ☐ Two Pair		Special Features:	Yes	No	(Extra Charge, if any)	Frames	
☐ Single Vision	$_____	Plastic Lenses	☐	☐	$_____	☐ Existing	$_____
☐ Bifocal	$_____	Oversize	☐	☐	$_____	☐ New	$_____
☐ Trifocal	$_____	Tinting (of any kind)	☐	☐	$_____	☐ _____	
☐ Lenticular	$_____	Blended focal	☐	☐	$_____	_____	
☐ _____	$_____	Other _____	☐	☐	$_____	_____	

Aphakic? ☐ Yes ☐ No **TOTAL CHARGES (Including tax): $** _____

Contacts: Therapeutic? ☐ Yes ☐ No Aphakic? ☐ Yes ☐ No

Daily Wear Spherical Lenses	Daily Wear Toric	Flexible Wear
☐ Hard $_____	☐ Soft $_____	☐ Soft $_____
☐ Soft $_____	☐ Gas Permeable $_____	☐ Gas Permeable $_____
☐ Gas Permeable $_____		

Other $

Supplier's Name, Address and ZIP Code	Tax ID Number (TIN)
	Telephone Number
Signature of Physician or Optometrist	NPI
	Date Signed

5. EMPLOYEE/RETIREE RELEASE INFORMATION

Employee/Retiree/Patient/Authorized Person's signature (read before signing). I authorize the release of any medical information necessary to process this claim from my provider of service or any insurance company involved in final benefit determination.

If allowed by the participating Blue Cross or Blue Shield Plan, I direct payment to be made to:

☐ The provider of service ☐ The employee/retiree

Signature ▶ _____ Date _____

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance.