Humana Specialty Benefits

Out-of-network vision claim form

HUMANA®
Guidance when you need it most

Date of service: ______________________________

Group name: ______________________________

Subscriber name: ______________________________

Subscriber ID: ______________________________

Subscriber date of birth: ______________________________

Patient name: ______________________________

Patient date of birth: ______________________________

Please provide the subscriber's current mailing address:

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Please place an "X" in the box next to each service you received, and include the dollar amount you were charged for the service.

- ❑ Exam $ __________
- ❑ Fitting of contacts $ __________
- ❑ Contacts $ __________
- ❑ Single vision lenses $ __________
- ❑ Bifocal lenses $ __________
- ❑ Trifocal/Progressive lenses $ __________
- ❑ Frame $ __________

Please complete and sign this form. Copies of your itemized receipts must be included.

If you need help filling out this form, please contact Customer Care at (800) 865-3676.

I authorize the release of records to process this claim.

Signature ______________________________ Date ______________________________

Submit claims to: Humana Specialty Benefits, P.O. Box 14311, Lexington, KY 40512-4311