



POST CATARACT- Eye Glasses/Contact Lens Reimbursement Form

- Please use this form for reimbursement of your **Post-Cataract Eyewear benefit only**.
- Reimbursement forms must be received no later than one year after the date you paid for the service.
- Please PRINT. For more information about completing the form, see the reverse side.

Member Information (for the specific member using this benefit):

Member ID #: Ex: 820000000-00	8										0	0
Member's Last Name:	First Name:					Middle Initial:			Date of Birth:			
Address:	City/State/Zip Code:					Phone Number:						
Name, address, phone number of service provider:												
Total number of receipts attached:						Place of Service:			11			
Are these eyeglasses for Post Cataract Surgery? (check YES or NO)						<input type="radio"/> YES (See reverse)			<input type="radio"/> NO			
Date of Cataract Surgery:						MM/DD/YYYY						
Date of Purchase: (MM/DD/YYYY)			Type of Service (Circle all that applies):				Amount Paid:					
			Eye Glass Frames– V2020									
			Eye Glass Lenses – V2100									
			Contact Lenses – V2500									

Certification and Authorization: (this form must be signed below)

I authorize the release of any information to MVP Health Care about my eye glasses/contact lens utilization. I certify that the information provided in support of this submission is complete and accurate. It has not and will not be submitted for reimbursement under any other health plan coverage (such as a Flexible Spending Account).

Subscriber's signature

Date

Any person who knowingly files a reimbursement request containing any misrepresentation or any false, incomplete or misleading information is guilty of a criminal act punishable under law and may be subject to civil penalties.

Return to: MVP Health Care, Medicare Advantage Eye Glasses/Contact Lens, P.O. Box 2207, Schenectady, NY 12301. (See reverse for guidelines on completing this form.)

For MVP Internal Use Only:

PIN: DR EYEWEAR

NPI: 1999999984

EIN: 199999998

Cataract Dx: Z961

How to Submit Your POST CATARACT Eye Glasses/Contact Lens Reimbursement Request

In order to process your request promptly, please refer to the following guidelines to ensure that all necessary information is included.

1. This form may be used by MVP Medicare Advantage members when submitting a reimbursement request for your post cataract surgery eyewear benefit. A separate form must be completed for each eligible member of your household.
2. The following items are not covered: safety glasses required by employers, non-prescription eyeglasses; non-prescription sunglasses and non-prescription contact lenses; extended-wear contact lenses; and non-prescription sports-related protective eyewear. Progressive lenses and tinted lenses are only covered if medically necessary.
3. Medicare allows one pair of eyeglasses or contact lenses after each cataract surgery. If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two pairs of eyeglasses after the second surgery.
4. All reimbursement forms must be received by MVP Health Care no later than one year after the date you paid for the service.
5. Attach the pre-printed, paid original receipt showing the type of service:
 - You must pay for the service before submitting a request for reimbursement.
 - For each item you are requesting, you must attach a copy of itemized bills, statements or receipts pre-printed or stamped or on company letterhead with the service provider's name and address.
 - Balance forward/prior balance statements are not acceptable.
 - Your claim form must include the following information:
 - Your name and MVP member ID number
 - The name and address of the provider
 - Are these eyeglasses for post-cataract surgery? If so, include date of cataract surgery.
 - The type of service provided (circle all that applies)
 - The date of purchase
 - Your out-of pocket cost for the service
6. MVP Health Care reserves the right to refuse reimbursement if the service provider does not meet benefit and quality standards as determined by MVP Health Care.
7. Sign this form and return it to: MVP Health Care
Medicare Advantage Eye Glasses/Contact Lens
P.O. Box 2207
Schenectady, NY 12301
8. Please allow 4-6 weeks for reimbursement (as long as your request is complete and accurate).
9. Please visit our website at **www.mvphealthcare.com** for more information about your eyewear benefit.

MVP Health Care is dedicated to prompt and accurate reimbursements to our health plan participants. By following these instructions and filling out the reimbursement form completely, you will help us process your request in a satisfactory manner. Thank you!