



Group Vision Claim Office
 P.O. Box 14389
 Baton Rouge, LA 70898-9100
 Phone: (888) 400-9304 or (225) 400-9304
 www.unum.com

Vision Claim Form

Return completed form via fax **(855) 400-9307**, email **VisionClaims@Unum.com**, or mail to the address above.

The following information is required with your DETAILED RECEIPT for reimbursement:

Subscriber Information			Patient Information		
1. Subscriber social security number or member ID number:			9. Patient relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
2. Subscriber name (Last name, First name, MI):			10. Patient name (Last name, First name, MI):		
3. Subscriber's address:			11. Patient's address:		
City:	State:	Zip code:	City:	State:	Zip code:
4. Subscriber birth date: ____/____/____ MM DD YY	5. Subscriber gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		12. Patient birth date: ____/____/____ MM DD YY	13. Patient gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
6. Email address:	7. Telephone: (____) _____		14. Email address:	15. Telephone: (____) _____	
8. Subscriber policy/Group number:			16. Patient status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student		
			17. Is patient covered under a medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient covered under another vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Attach copy of receipt and supporting documentation.

Date of Service (MM/DD/YY)	Procedure Code	Diagnosis Code(s)	Amount Billed	Amount Paid
1. ____/____/____	_____	_____	\$ _____ . ____	\$ _____ . ____
2. ____/____/____	_____	_____	\$ _____ . ____	\$ _____ . ____
3. ____/____/____	_____	_____	\$ _____ . ____	\$ _____ . ____
4. ____/____/____	_____	_____	\$ _____ . ____	\$ _____ . ____
5. ____/____/____	_____	_____	\$ _____ . ____	\$ _____ . ____

Provider Information			
Provider federal tax ID or NP ID:		Eye care professional name:	
Facility name:		Facility address:	
City:	State:	Zip:	Telephone: (____) _____

Patient's or authorized person's signature:

I authorize the release of any medical or other information necessary to process this claim.

Signature: _____ Print name: _____ Date: _____

NOTE: Missing or inaccurate information on claim forms will cause delays in claim processing.

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