

# MyBenefits

## Submit your out-of-network vision claim online

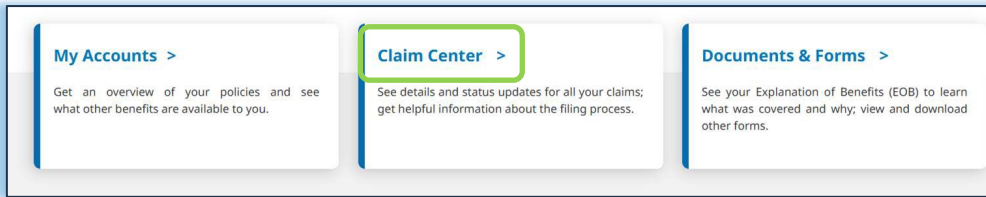


Use this MyBenefits online form to submit a claim for the following:

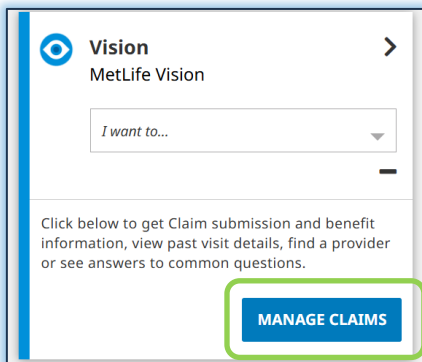
- Services rendered by an out-of-network provider, or
- Services rendered by an in-network provider, **where you took advantage of sales, coupons, or other in-store specials.**

Claims submitted here will be reimbursed according to your plan's **out-of-network rates.**

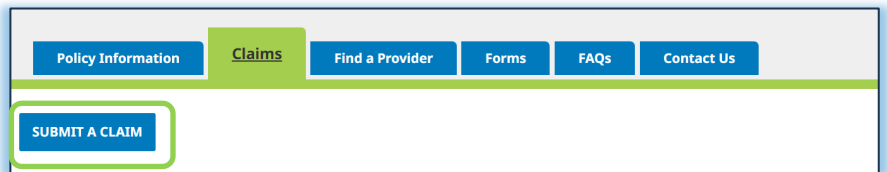
1. Once registered and logged in to [metlife.com/mybenefits](https://metlife.com/mybenefits), from the MyBenefits Homepage click on **'Claim Center'**.



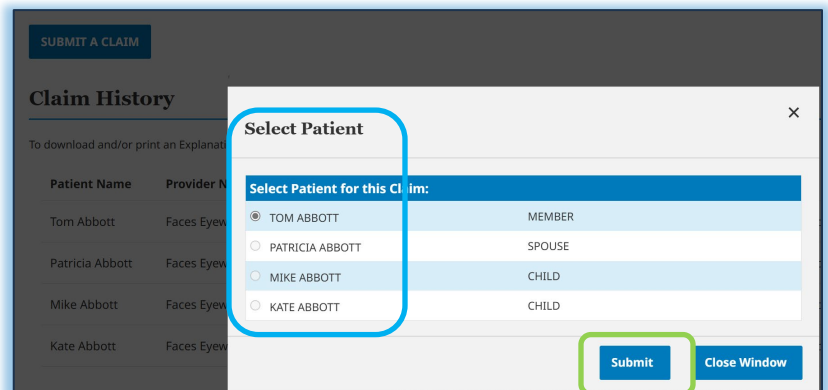
2. On the **Vision card**, click on **'Manage Claims'**.



3. Next, click on **'Submit a Claim'**.



4. A box will pop-up to select the patient/person you are submitting the claim for. Select the person and click **'Submit'**.



- After choosing the person you are submitting a claim for, the following page appears. Enter the requested information in each section.

Claims submitted here will be reimbursed according to your plan's **out-of-network rates**. You may receive full or partial reimbursement for services from out-of-network providers. However, this claim submission does not guarantee any reimbursement. Review your benefits for details.

Use this form to submit a claim for the following:

- Services rendered by an Out-of-Network provider, or
- Services rendered by an In-Network provider, where you took advantage of sales, coupons, or other in-store specials.

**Step 1 Patient Selected**

Patient Name	Relationship	Action
TOM ABBOTT	MEMBER	<a href="#">Change Patient</a>

**Step 2 Date of Service**

If you have more than one receipt, please enter the earliest service date.

April

7

2025

You can change the patient here if needed.

Complete the 'Date of Service'.

Click on 'Add Service to Claim' to enter your services/expenses.

[Add Service to Claim](#)

**Step 3 Services Received**

Based on your receipt(s), use the "Add Service to Claim" button to enter the expenses you incurred for the services you received.

Service	Expenses Incurred	Action
Eye Examination	\$ 200.00	<a href="#">Delete</a>
<b>Total Expenses Incurred:</b>	<b>\$ 200.00</b>	

Choose your 'Service Type' from the drop-down box. Enter the amount you paid for that service in the 'Expenses Incurred' field and click 'Submit'.

If you have more than one Service Type, click on 'Add Service to Claim' again and then click 'Submit'.

**Add Service** ✕

**Service Type:** Eye Examination

**Expenses Incurred:** \$ 200.00

[Submit](#) [Close Window](#)

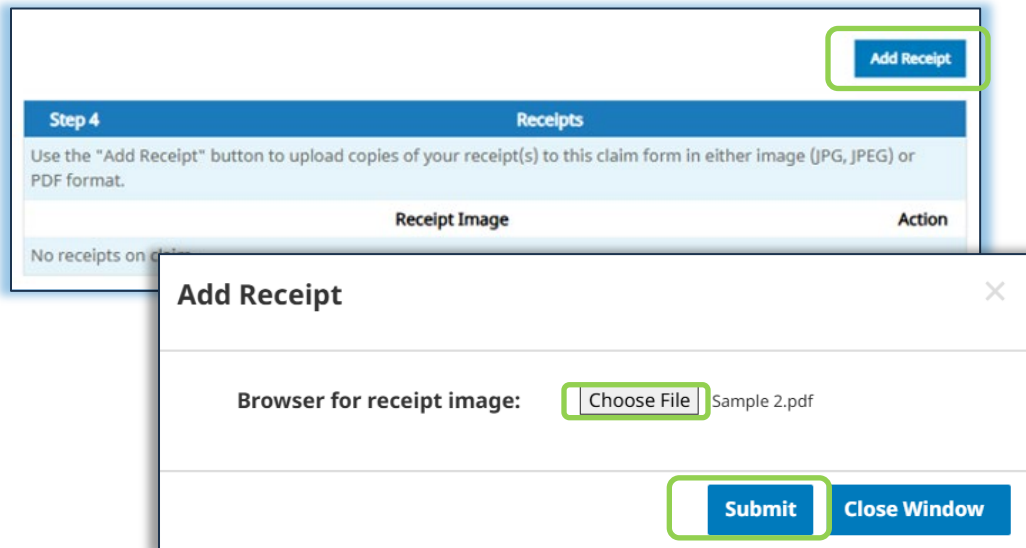
[Add Service to Claim](#)

**Step 3 Services Received**

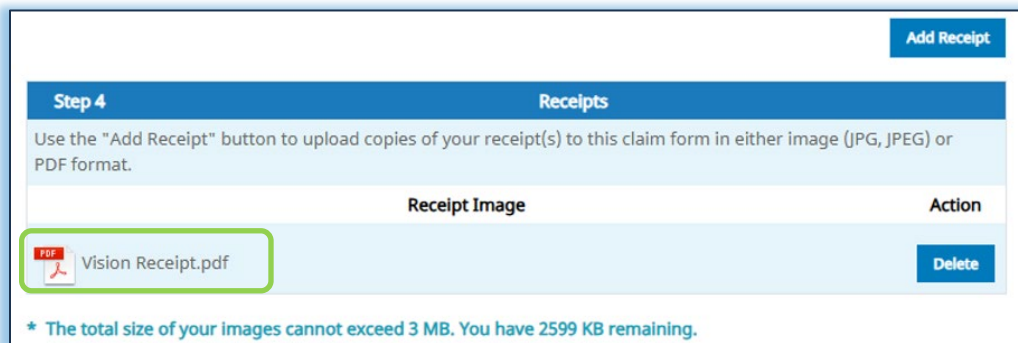
Based on your receipt(s), use the "Add Service to Claim" button to enter the expenses you incurred for the services you received.

Service	Expenses Incurred	Action
Eye Examination	\$ 200.00	<a href="#">Delete</a>
Frames	\$ 150.00	<a href="#">Delete</a>
Single Vision Lenses	\$ 50.00	<a href="#">Delete</a>
<b>Total Expenses Incurred:</b>	<b>\$ 400.00</b>	

6. After entering your services/expenses incurred, click on **'Add Receipt'** to upload your **itemized receipts**.
7. Upload your receipt by clicking on **Choose File**. After choosing your file, click **Submit**.
  - You may enter more than one receipt, up to 3 MB.



Your file name will show under the **Receipts** section.



8. If you visited an **in-network provider** for this service, enter the provider's name and phone number.

**Step 5** Did You See an In-Network Provider?

If you are filing this claim for services rendered by an In-Network provider, please enter the provider's name and phone number in Step 5 below. Otherwise, skip Step 5.

Provider Name:

Provider Phone:

9. Next, **certify** the information is correct by **checking off the box**.

**I certify** that the information I am submitting is correct, and I authorize the provider to release appropriate information necessary to process this claim to plan provisions.

[View Claim Summary](#)

10. Once you have certified the information is correct, you'll have a chance to **'View Claim Summary'**.

I certify that the information I am submitting is correct, and I authorize the provider to release appropriate information necessary to process this claim to plan provisions.


[View Claim Summary](#)

11. You can then choose to either **'Edit Claim'** or **'Submit Claim'**.

Please review the claim data below.  
Then, click the "Submit Claim" button at the bottom of this page to submit the claim or click the "Edit Claim" button to make changes to this claim before submitting.

Patient Selected	
Patient Name:	TOM ABBOTT
Relationship:	MEMBER
Policyholder:	TOM ABBOTT
Mailing Address:	123 MAPLE STREET APPLETON, WI 12345

Services Received		
Service	Expenses Incurred	Date of Service
Eye Examination	\$ 200.00	4 / 7 / 2025
<b>Total Expenses Incurred:</b>	<b>\$ 200.00</b>	

Receipts	
 Vision Receipt.pdf	

The actual reimbursement amount may differ from above.  
You should receive your reimbursement within 10 - 15 business days.

[Edit Claim](#) [Submit Claim](#)

# Prefer to mail in a paper form with receipts?

By clicking on the **'Forms'** tab, you can **download a form and mail it** to the address below. Follow the directions and fill out the form in its entirety.

- Complete a form **for each patient** and/or plan.

The screenshot shows a website navigation bar with the following tabs: Policy Information, Claims, Find a Provider, **Forms** (highlighted), FAQs, and Contact Us. Below the navigation bar is a section titled "Forms and Publications" with the text: "While the information presented is believed to be accurate as of the publication date, it is subject to change without notice." Below this text are three bullet points:
 

- HIPAA Authorization Form
- **Member Reimbursement Claim Form** (highlighted with a blue border)
- Nominate a Provider

 At the bottom of this section, it says: "Other available forms may be obtained by calling Member Services at **1-833-393-**"

Verify the information on the form is correct, attach itemized receipts, and **mail form and receipts to:**

**MetLife Vision (Davis Vision)**  
**Attn: Claims Processing**  
**P.O. Box 509**  
**Troy, New York 12181**

The form is titled "VISION BY METLIFE MEMBER REIMBURSEMENT FORM". It includes "FORM INSTRUCTIONS" and sections for "PATIENT", "MEMBER", "CLAIM", "PROVIDER", and "PRINT PERSON".

**FORM INSTRUCTIONS:**  
 The form must be filled out by the member. All fields flagged with an asterisk (\*) are required. The form is fillable, so you do not have to hand write. Fill it out on a computer, print it, and mail it in. If you decide to hand write, use blue or black ink.

**Patient section:**  
 1. Select the patient's relation to the member. Choose only one.  
 2. Enter the patient's date of birth in the following format: Month/Day/Four-Digit Year  
 3. Select a gender. Choose only one.  
 4. Enter the patient's last name and first name.  
 5. Enter the address, city, state and ZIP code.  
 6. The patient's middle initial and ZIP+4 are optional.

**Member section:**  
 1. Enter the Last 4 Digits of the member's SSN.  
 2. If the patient is the member, select 'Member information below is the same as Patient.'  
 3. Otherwise, enter the member's information:  
 a. Enter the member's date of birth in the following format: Month/Day/Four-Digit Year  
 b. Sex  
 c. Eye  
 d. Eye  
 e. The

**CLAIM section:**  
 1. Enter the D  
 2. Enter the ad  
 3. Select a Mem  
 4. If another r

**PROVIDER section:**  
 1. If the provi  
 2. If the offic  
 3. Step #1 or  
 4. Enter the fi  
 5. The second  
 6. Only the fo

**PRINT PERSON:**  
 By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information I have provided above is true and complete to the best of my knowledge. I acknowledge that the above-named provider is not a MetLife In-Network Vision Provider and that MetLife Vision cannot guarantee my eye care and/or eyewear satisfaction.  
 New York residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.  
 Claimant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**How to Submit This Form**  
 Mail to:  
 MetLife Vision (Davis Vision / Superior Vision)  
 Attn: Claims Processing  
 PO Box 509  
 Troy, NY 12181

October 2023

MetLife vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claims and network administration services are provided through Davis Vision, Inc. ("Davis Vision"), a New York corporation. Davis Vision is part of the MetLife family of companies. Like most group benefit programs, Davis Vision by MetLife plans contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

