

MyBenefits

Submit your out-of-network vision claim online

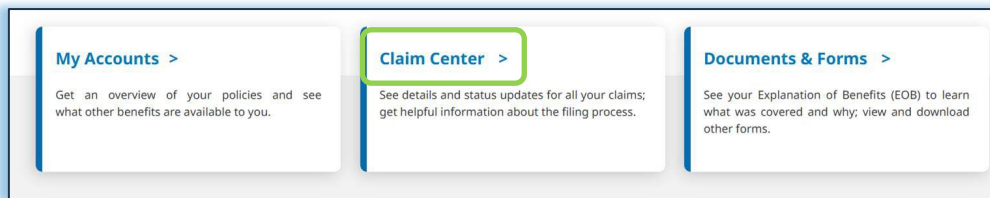


Use this MyBenefits online form to submit a claim for the following:

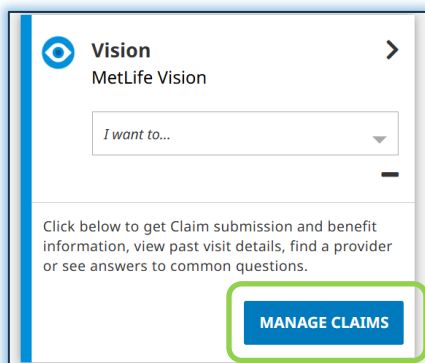
- Services rendered by an out-of-network provider, or
- Services rendered by an in-network provider, **where you took advantage of sales, coupons, or other in-store specials.**

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

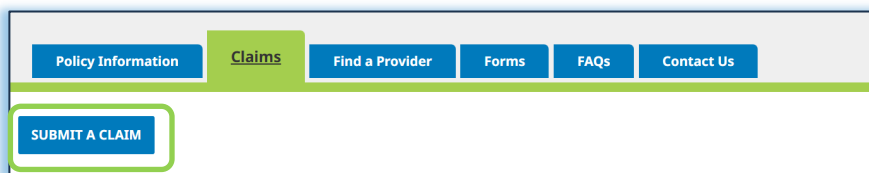
1. Once registered and logged in to metlife.com/mybenefits, from the MyBenefits Homepage click on **'Claim Center'**.



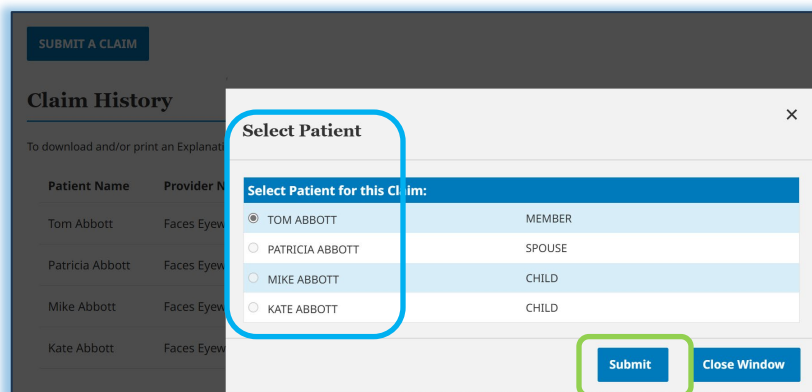
2. On the **Vision card**, click on **'Manage Claims'**.



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	Change Patient

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	Delete
Total Expenses Incurred:	\$ 200.00	

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](#)

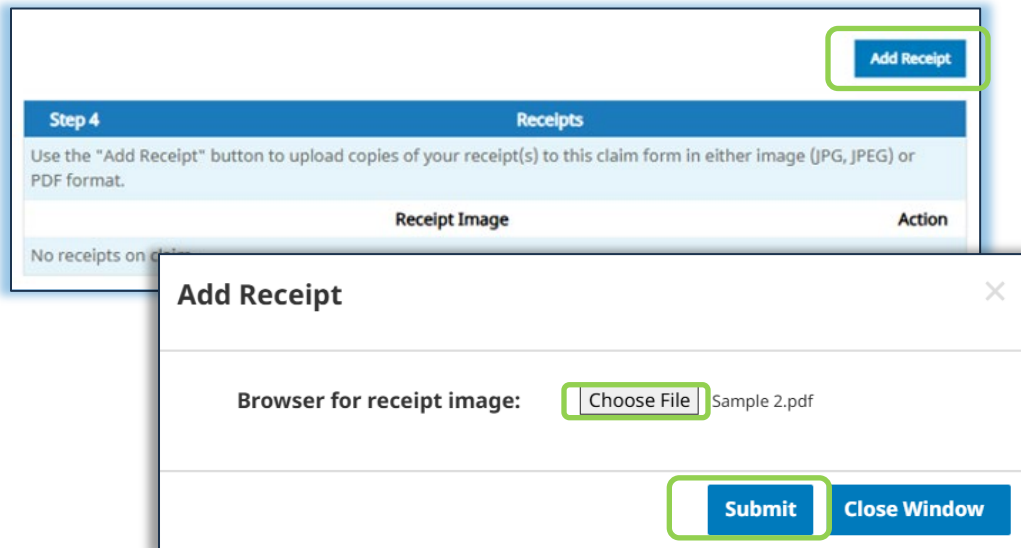
[Add Service to Claim](#)

Step 3 Services Received

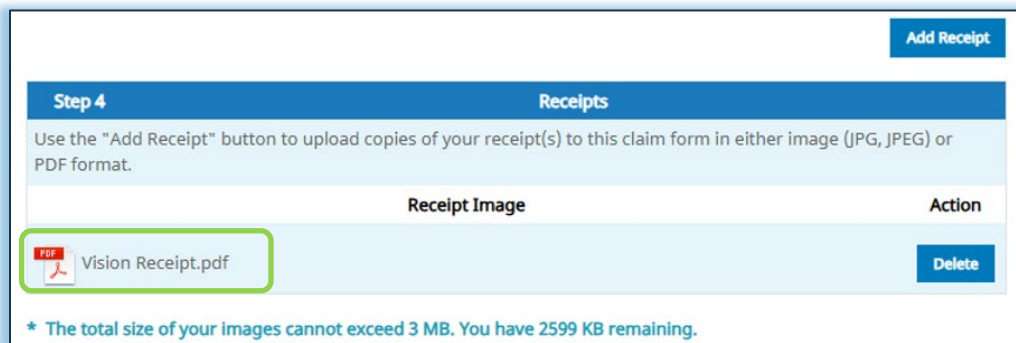
Based on your receipt(s), use the "Add Service to Claim" button to enter the expenses you incurred for the services you received.

Service	Expenses Incurred	Action
Eye Examination	\$ 200.00	Delete
Frames	\$ 150.00	Delete
Single Vision Lenses	\$ 50.00	Delete
Total Expenses Incurred:	\$ 400.00	

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
Total Expenses Incurred:	\$ 200.00	

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.

Policy Information **Claims** **Find a Provider** **Forms** **FAQs** **Contact Us**

Forms and Publications

While the information presented is believed to be accurate as of the publication date, it is subject to change without notice.

- HIPAA Authorization Form
- **Member Reimbursement Claim Form**
- Nominate a Provider

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

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:

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

Member section:

- Enter the Last 4 Digits of the member's SSN.
- If the patient is the member, select 'Member information below is the same as Patient.'
- Otherwise, enter the member's information:
 - Enter the member's date of birth in the following format: Month/Day/Four-Digit Year
 - Sex
 - Eye
 - Ear
 - Other

CLAIM SECTION:

To request reimbursement, complete and print this form, enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.

1. Enter the ID
 2. Enter the address
 3. Select a Member
 4. If another person is submitting the claim, select the relationship to the member.

PATIENT:

Relationship to Member: (choose one)
 Member Domestic Partner Dependent Parent Disabled Dependent
 Spouse Child Full-Time Student Other

PROVIDER SECTION:

Date of Birth*: (mm/dd/yyyy) Gender*: Male Female MI: _____
 Last Name*: _____ First Name*: _____
 Address*: _____
 City*: _____ State*: _____ ZIP Code*: _____ ZIP+4: _____
 Last 4 Digits of SSN*: _____

MEMBER:

Date of Birth*: (mm/dd/yyyy) Member information below is the same as Patient Gender*: Male Female
 Last Name*: _____ First Name*: _____ MI: _____
 Address 1*: _____ Address 2*: _____
 City*: _____ State*: _____ ZIP Code*: _____ ZIP+4: _____

CLAIM:

Date of Service*: _____ Another insurance company made payments to you, another insurer, or the doctor's office. If so, attach a copy of the statement showing payment.
 Exam: \$ _____ Lens Type*: (choose one)
 Single Progressive
 Bi-focal Lenticular
 Lens tints or coatings: \$ _____ Tri-focal
 Contact Lens Exam / Fitting Evaluation: \$ _____
 Contacts: \$ _____

PROVIDER:

Last Name: _____ First Name: _____
 Office Name: _____
 Address 1*: _____ Address 2*: _____
 City*: _____ State*: _____ ZIP Code*: _____ ZIP+4: _____

PRINT & SIGN:

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 (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 Superior Vision Services, Inc. ("Superior Vision"), a Delaware corporation. Superior Vision is part of the MetLife family of companies. Like most group benefit programs, Superior 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.

