

MyBenefits

Submit your out-of-network vision claim online



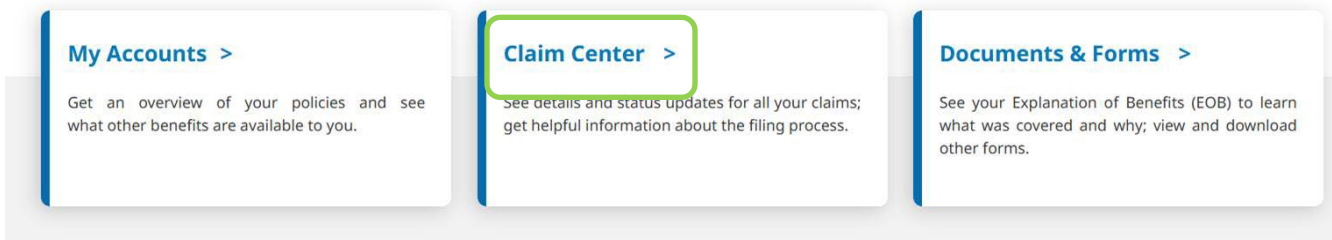
Use this MyBenefits online form to submit a claim for the following:

- Services rendered by an **out-of-network provider**.

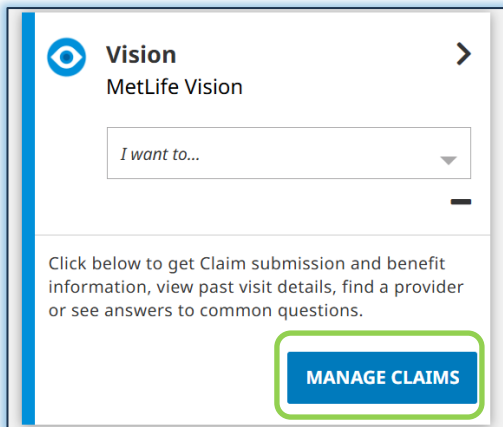
Before submitting a claim through MyBenefits, check with your provider to see if they can submit an out of network claim on your behalf.

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

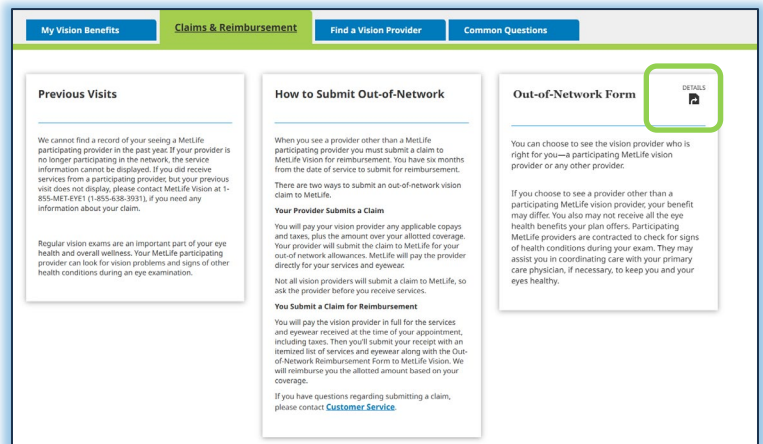
1. Once registered and logged in to metlife.com/mybenefits, from the MyBenefits Homepage click on the 'Claims Center'.



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



3. Under the **Claims & Reimbursement tab**, click on 'Details'.



4. Next, click the link to the 'online form'.

My Vision Benefits **Claims & Reimbursement** **Find a Vision Provider** **Common Questions**

Out-of-Network Form

Requesting Your Reimbursement

If you have already visited an out-of-network vision provider, please follow the steps below to request reimbursement.

1. Click Continue to complete the [online form](#).

- OR -

Download the form as a PDF in [English](#) or in [Spanish](#). ([Download Acrobat Reader](#))

2. Follow the directions and fill out the form in its entirety.
3. When finished with the online form, select "View and Print Form"
4. Complete a form for each patient and/or plan.
5. Verify information on form is correct, attach itemized receipts, and mail form and receipts to:

5. An online form will appear. Enter all the applicable information, upload **itemized receipt(s)** and click 'Submit'.


My Vision Benefits **Claims & Reimbursement** **Find a Vision Provider** **Common Questions**

Out-of-Network Form

1 Provide Subscriber Information

Subscriber Information
All fields are required unless noted.

Name: John S Claimant


Date of Birth 

Check this box if foreign address

Street Address

City

State Zip Code

Date Services Were Received 

Email Address (Optional)

Phone Number (Optional)

Prefer to mail in a paper form with receipts?

You may also **download a form and mail it** to the address below. Follow the directions and fill out the form in its entirety.

- When finished with the form, select **'View and Print Form'**.
- Complete a form **for each patient** and/or plan.

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MetLife Vision
Attn: Claims Processing
P.O. Box 495918
Cincinnati, OH 45249-5918

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

MetLife
Metropolitan Life Insurance Company

METLIFE VISION MEMBER REIMBURSEMENT FORM

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.

MetLife Vision
 P.O. Box 495918
 Cincinnati, OH 45249-5918

PATIENT	Relation to Member* (choose one)			
	<input type="radio"/> Member	<input type="radio"/> Domestic Partner	<input type="radio"/> Dependent Parent	<input type="radio"/> Disabled Dependent
	<input type="radio"/> Spouse	<input type="radio"/> Child	<input type="radio"/> Full-Time Student	<input type="radio"/> Other
	Date of Birth* (mm/dd/yyyy)	Gender*:	<input type="radio"/> Male	<input type="radio"/> Female
Print and Sign	Last Name*:	First Name*:	MI:	
1. Revise	Address*:			
2. Review	City*:	State*:	ZIP Code*:	ZIP+4:
3. Print	Last 4 Digits of SSN*:			
4. Sign	<input type="checkbox"/> Member information below is the same as Patient			
5. Date	Date of Birth* (mm/dd/yyyy)	Gender*:	<input type="radio"/> Male	<input type="radio"/> Female
6. Only	Last Name*:	First Name*:	MI:	
	Address 1*:		Address 2:	
	City*:	State*:	ZIP Code*:	ZIP+4:
	Date of Service*:	<input type="checkbox"/> Another insurance company made payments to you, another insurer, or the doctor's office. If so, attach a copy of the statement showing payment.		
CLAIM	Exam:	\$	Lens Type* (choose one)	
	Frame:	\$	<input type="radio"/> Single	<input type="radio"/> Progressive
	Lens:	\$	<input type="radio"/> Bi-focal	<input type="radio"/> Lenticular
	Lens tints or coatings:	\$	<input type="radio"/> 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:	

Vision Insurance is provided by Metropolitan Life Insurance Company (MetLife), New York, NY. Certain claim and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with MetLife or its affiliates. Like most group benefit programs, benefit programs offered by MetLife and its affiliates 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. VSP is a registered trademark of Vision Service Plan.

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