MetLife
Metropolitan Life Insurance Company

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. Select a gender. Choose only one.
    c. Enter the member's last name and first name.
    d. Enter the first address line, city, state, and ZIP code.
    e. The member's middle initial, second address line, and ZIP+4 are optional.

Claim section:

1. Enter the Date of Service in the following format: Month/Day/4-Digit Year.
2. Enter the amount charged for each applicable line item. Ensure they match the receipts.
3. Select a Lens Type.
4. If another insurance company is involved, check the box and attach a copy of the statement showing payment.

Provider section:

1. If the provider's name is known, enter the provider's last name and first name.
2. If the office name is known, enter the provider's office name.
3. Step #1 or #2 or both must contain a value.
4. Enter the first address line, city, state, and ZIP code.
5. The second address line and ZIP+4 are optional.

Print and Sign section:

1. Review the completed form for accuracy.
2. Read the acknowledgement paragraph.
3. Print the form.
4. Sign the form.
5. Date the form in the following format: Month/Day/Four-Digit Year.
6. Only the form on the next page needs to be mailed in. All other pages are for reference.

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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
PO Box 495918
Cincinnati, OH 45249-5918

PATIENT

Relation to Member*: *(choose one)*

◯ Member ◯ Domestic Partner ◯ Dependent Parent ◯ Disabled Dependent
◯ Spouse ◯ Child ◯ Full-Time Student ◯ Other

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

MEMBER

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

CLAIM

Date of Service*: *(mm/dd/yyyy)*

☐ 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.....	$
Frame.....	$
Lens	$
Lens tints or coatings.....	$
Contact Lens Exam / Fitting Evaluation.....	$
Contacts.....	$

Lens Type*: *(choose one)*

◯ Single ◯ Progressive
◯ Bi-focal ◯ Lenticular
◯ Tri-focal

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: _____

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FRAUD WARNINGS

Before signing this form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly presents false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Idaho, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

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Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false of fraudulent claim for penalty of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

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Language Assistance Services Available

English: ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-877-7195 (TTY: 1-800-428-4833).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-877-7195 (TTY: 1-800-428-4833).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-877-7195 (TTY: 1-800-428-4833).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-877-7195 (TTY: 1-800-428-4833).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-877-7195 (TTY: 1-800-428-4833))번으로 전화해 주십시오.

Tagalog –Filipino: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-877-7195 (TTY:1-800-428-4833).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-877-7195 (телетайп: 1-800-428-4833).

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-877-7195 (TTY (հեռատիպ)՝ 1-800-428-4833).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-877-7195 (ATS : 1-800-428-4833).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-877-7195 (TTY: 1-800-428-4833)まで、お電話にてご連絡ください。

Tongan: FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-800-877-7195 (TTY: 1-800-428-4833).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-877-7195 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-428-4833).

Cambodian: យុរយ័តុះ បើវើសនិនជាអនិកននិយាយ ភនិសនិខំមរ, បសវាជំនយខនិនកភាសា បនិយមិនគនិត្ឈនិល គឺអនិចមនិនសំរាវ់រំប រអនិក។ ចរ ទរសន័ពិ 1-800-877-7195 (TTY: 1-800-428-4833)។

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-877-7195 (TTY: 1-800-428-4833) 'ਤੇ ਕਾਲ ਕਰੋ।

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German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-877-7195 (TTY: 1-800-428-4833).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-877-7195 (መስማት ለተሳናቸው: 1-800-428-4833).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-877-7195 (телетайп: 1-800-428-4833).

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-877-7195 (टिटिवाइ: 1-800-428-4833)।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-877-7195 (TTY: 1-800-428-4833).

Sudan (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-877-7195 (TTY: 1-800-428-4833).

Thai: เรียน: ถาคณพดภาษาไทยคณสามารถใชบรการชวยเหลอทางภาษาไดฟร โทร 1-800-877-7195 (TTY: 1-800-428-4833).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບລການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບເສັງຄ່າ, ແມ່ນມ່ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-877-7195 (TTY: 1-800-428-4833).

Cushite/Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-877-7195 (TTY: 1-800-428-4833).

Persian (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-877-7195 تماس بگیرید (TTY: 800-428-4833-1).

Arabic:

ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 7195-877-800-1(رقم الهاتف الصم والبكم: 1-800-428-4833-1).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-877-7195 (TTY: 1-800-428-4833.)

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-877-7195 (TTY: 1-800-428-4833) पर कॉल करें।

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