MetLife Vision Member Reimbursement Form

MetLife

To request reimbursement, complete this form (in blue or black ink), 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 997565
Sacramento, CA 95899-7565

Group# 158424

Ref #

Member Information

Policyholder/Employee ID or Last 4 Digits of SSN

Date of Birth ___ / ___ / ___

First Name Last Name

Address Apt

City State Zip

( ) Daytime Phone #

Employer / Group _____

Patient Information

First Name Last Name

Member ☐ Spouse ☐ Child ☐ Domestic Partner ☐

Date of Birth ___ / ___ / ___

If the patient is a child over the age of 18:

Is the child a full-time student? Yes ☐ No ☐ Is the child disabled? Yes ☐ No ☐

Claim Information (Dollar amounts must match the attached receipts)

Exam $.

Frame $.

Lens $.

Lens tints or coatings $.

Contacts $.

Total Paid $.
(Do not add tax or shipping)

Lens Type: (Choose one)

Single ☐ Progressive ☐

Bi-Focal ☐ Lenticular ☐

Tri-Focal ☐ Contacts ☐

Date services were received ___ / ___ / ___

Check here if another insurance company has made payment to you, another insurer or the doctor's office ☐

If so, attach a copy of the statement showing payment

Provider Information

Store or Dr Name

( ) Store or Dr Phone Number

I acknowledge that the above-named provider is not a MetLife Vision provider and that MetLife Vision cannot guarantee my eyecare and/or eyewear satisfaction. I also attest that the information I have provided above is complete and accurate.

I fully understand and consent to the above statement: _____ Date: _____

Benefits are underwritten by Metropolitan Life Insurance Company, New York, NY.
For your protection state law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment is subject to criminal and civil penalties.