# OUT-OF-NETWORK FORM

You can also complete your request online at ***www.visioncaredirect.com/members/oon***

## PATIENT INFORMATION

LAST NAME ____________________ FIRST NAME ____________________ MIDDLE INITIAL ______

ADDRESS ____________________ CITY ____________________ STATE ______ ZIP CODE ______

PHONE ____________________ DATE OF BIRTH ____________________ MEMBER ID ____________________

## PROVIDER (DOCTOR) INFORMATION

DOCTOR'S NAME ____________________ PHONE ____________________

ADDRESS ____________________ CITY ____________________ STATE ______ ZIP CODE ______

## PAYMENT REQUEST

| | | | | | |
|---|---|---|---|---|---|
| **SERVICES** | $ ______ EXAM | $ ______ REFRACTION | $ ______ DILATION | $ ______ CONTACT LENSES | $ ______ FRAME |
| **LENSES** | $ ______ SINGLE VISION | $ ______ BIFOCAL | $ ______ TRIFOCAL | $ ______ PROGRESSIVE | $ ______ OTHER |
| **LENS OPTIONS** | $ ______ ANTI-REFLECTIVE | $ ______ SCRATCH | $ ______ POLYCARBONATE | $ ______ TINT | $ ______ OTHER |

DATE OF SERVICE - ____________________ TOTAL AMOUNT PAID - $ ____________________

## AUTHORIZATION

**Patient or Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process this request for payment. By signing below, I acknowledge that the above information is true and correct.

SIGNED ____________________ DATE ____________________

**Mail this Out-Of-Network payment request along with itemized receipts to:**

Vision Care Direct
Out-of-Network Request
405 S Holland, Suite A
Wichita, KS 67209