

FOR INTERNAL USE ONLY:

- Place of service: OF
- CPT Code: V2799
- Diagnosis Code: 367.89
- Tin: 0-069000010

MEDICA®



MEDICA SOLO EYEWEAR CLAIM FORM

This policy allows \$50 towards eyewear (glasses, frames, or contact lenses) per calendar year. If you pay for your eyewear at the time of purchase, please use this form to submit your claim.

Send the completed form and copies of your receipts to:

Medica Claims
PO Box 30990
Salt Lake City, UT 84130

If you have questions, please call Medica Customer Service at 952-992-1805 or 1-866-894-8051. TTY callers, please call the National Relay Center at 1-800-855-2880 and ask for 1-800-894-8051.

To be completed by Policyholder: (Please Print)

Medica Policyholders Name:	
Patient's Name:	Patient's Date of Birth:
Medica Identification Number:	
Date of Purchase:	
Home Telephone Number:	
Total Amount Paid for Eyewear:	
Name of Vision Clinic or Provider:	
Clinic Location (City, State, Zip):	