MetLife Vision Member Reimbursement Form

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

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: _____