VISION CARE DIRECT
The vision plan your eye doctor recommends™

Standard Open Access Schedule - Nebraska

Vision Care Direct is committed to providing you with the highest quality vision care available within our panel of qualified, private practice doctors. We understand that there may be circumstances in which you may need to see an Open Access provider. Please use this form to guide you in filing open access request for payments with Vision Care Direct.

Open Access Request for Payment Instructions

- Visit an eye care professional and receive services and/or materials. Member will pay out of pocket for these services and/or materials.
- Please remit completed Request for Payment form and copies of all receipts to:

  Vision Care Direct
  Open Access Request for Payment
  3515 W. Central Ave.
  Wichita, KS 67203

- Member will be reimbursed allowable charges within 45 days of receipt of request for payment directly from the Vision Care Direct Office.

Please Note

All requests for payments must be received 45 days from the date service and/or materials were rendered.

Any services or materials purchased and filed for compensation by Vision Care Direct will be deducted from the annual Open Access allowance for that member. The member is responsible for any costs incurred for services and/or materials in excess of his/her annual network allowance.

Open Access allowances are not available for Individual plans.

Allowances are significantly higher by using the Vision Care Direct network providers.

Allowance Description with Open Access Allowance comparison

Eye Exam	In Network	Open Access
Exam	100%	$ 50
Lenses		
Single Vision	100%	$ 50
Bifocal	100%	$ 75
Trifocal	100%	$ 100
Lenticular	100%	$ 100
Progressive (All Platinum plans)	$ 180	$ 100
Progressive (All other plans)	Member pays difference between progressive retail and trifocal retail	$ 100
Frame		
(Any frame)	Based on the frame allowance that is selected at time of enrollment. *(Typically $100, $130, $160 or $200.)*	$ 60
Contact Lenses *(In lieu of annual lens and frame benefit)*		
Cosmetic	Based on the contact lens allowance that is selected at time of enrollment. *Typically $105, $130, $160 or $200.)*	$ 80
Medically Necessary	$ 250	$ 80

Vision Care Direct ▪ 3515 W. Central Ave., Wichita, KS 67203 ▪ Toll Free: (877) 488-8900 Fax: (844) 810-8643

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Open Access Request for Payment Form

PATIENT INFORMATION			
LAST NAME		FIRST NAME	MIDDLE
ADDRESS			
CITY	STATE	ZIP	
DAYTIME PHONE		DATE OF BIRTH	
MEMBER (EMPLOYEE) INFORMATION			
LAST NAME		FIRST NAME	MIDDLE
MEMBER ID #		DATE OF BIRTH	
PROVIDER (DOCTOR) INFORMATION			
PROVIDER NAME		TELEPHONE	
ADDRESS			
CITY	STATE	ZIP	

REQUEST FOR PAYMENT			
DATE OF SERVICE		AMOUNT CHARGED FOR SERVICES **(Remember to include itemized receipts)**	
EXAM $	LENS $	FRAMES $	CONTACTS $
TYPE OF LENS (Please check lens type purchased) ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Lenticular ☐ Progressive			

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 Open Access Request for Payment form and receipts to:

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