VISION CARE DIRECT

The vision plan your eye doctor recommends™

Standard Out-of-Network Schedule

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 out of network provider. Please use this form to guide you in filing out-of-network request for payments with Vision Care Direct.

Out-of-Network 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 - OON 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 out-of-network 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.

Out-of-Network allowances are not available for Individual plans.

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

Allowance Description with Out-of-Network Allowance comparison

Eye Exam *(in-network member payment at time of service will be deducted)*	**In Network**	**Out-of-Network**
Exam	100%	$ 40
Lenses *(in-network member payment at time of service will be deducted)*		
Single Vision	100%	$ 30
Bifocal	100%	$ 45
Trifocal	100%	$ 55
Lenticular	100%	$ 75
Progressive (All Platinum plans)	$ 180	$ 60
Progressive (All other plans)	Member pays difference between progressive retail and trifocal retail	$ 60
Frame		
(Any frame)	Based on the frame benefit that is selected at time of enrollment. *(Typically $100, $130, $160 or $200.)*	$ 35
Contact Lenses *(In lieu of annual lens and frame benefit)*		
Cosmetic	Based on the contact lens benefit 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

VISION CARE DIRECT
The vision plan your eye doctor recommends™

Out-of-Network 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 Out-of-Network Request for Payment form and receipts to:

Vision Care Direct
Out-of-Network Request for Payment
3515 W. Central Ave.
Wichita, KS 67203