Lasik/Refractive Keratoplasty Reimbursement Form

Instructions for Completing this Form and Submitting Your Claim

MVP Health Care® is dedicated to prompt and accurate payment of claims to our plan participants. Following these instructions and completing the claim form in its entirety will help us process your claim in a timely manner. Claims submitted without complete documentation cannot be processed and will be returned to you.

Who should complete this form?

Eligible members can use this form to request reimbursement of up to $750 per member per lifetime for out of pocket costs for surgical correction of myopia through refractive keratoplasty, including the following surgeries: laser-assisted in-situ keratomileusis (LASIK); photo-refractive keratectomy; or radial keratotomy. Coverage includes pre-consultation and post-consultation visits.

See your plan contract or call member services at the number on your ID card to confirm that this benefit applies to your plan.

Submit the required documentation.

To ensure prompt processing of your claim reimbursement for services, the Lasik/Refractive Keratoplasty Reimbursement Form must be signed by the member and the Physician attesting that services were provided, and be accompied by proof of service and payment.

Proof of service can be in the form of a visit statement or an itemized receipt. The documents should include the Physician's name or practice name, the dates of service, and the services rendered with the amounts billed.

Proof of payment can be submitted as original itemized receipts or billing statements from the certified doula showing payment. Please keep copies for your records. Cash register receipts, canceled checks, money orders, credit card vouchers, or personal lists of services or bills stating only "balance forward" are not acceptable as substitutes for original bills.

If another insurance carrier has made payment on this service, an explanation of benefits from that carrier must be submitted with the claim.

How to submit your completed claim.

Submit your completed claim and all documentation to MVP by:

- **Mail** to CLAIMS SUBMISSION, MVP HEALTH CARE, PO BOX 2207, SCHENECTADY NY 12301-2207
- **Email** to **submitclaims@mvphealthcare.com**
- **Fax** to **518-395-1395**
- **Online** at **mvphealthcare.com**. *Sign In* to your online account and select *Medical Claim Reimbursement*. Only medical claims can be submitted online. MVP members must be at least 18 years of age to submit a claim online.

Questions? We're here to help!

Call the MVP Customer Care Center at the phone number on the back of your MVP Member ID card.

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Section 1: Patient and Subscriber Information *(please print)*

Patient Name *(first, middle initial, last)* | **Patient** Date of Birth | MVP Member ID No.

MVP Subscriber Name *(first, middle initial, last)* | Phone No. ( )

MVP Subscriber Street Address | City | State | Zip Code

Group Name | **Group** No. *(if applicable)*

Section 2: Provider and Billing Information *(contact your provider for the following)*

Provider Name | Phone No. ( ) | Date of Service

Provider Street Address | City | State | Zip Code

Tax ID No. | NPI No. | Provider Signature

Type of Service Performed

☐ **S0800 LASIK** ☐ **S0810 Photorefractive keratectomy (PRK)** ☐ **65771 Radial keratotomy**

Diagnosis

☐ **H52.1 Myopia**

Total Reimbursement Requested ► $

Are you covered under another insurance plan that provides coverage for the type of service being submitted? ☐ **Yes** ☐ **No**

If ***Yes***, provide the following information about that insurance:

Insurance Company Name | **Policyholder** Name

Policy or ID No. | Other Carrier Phone No. ( ) | Policy/Other Carrier Effective Date

Insurance Company Street Address | City | State | Zip Code

Section 3: Certification and Authorization to Release

By signing below, I certify that the above statements are correct. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

*Member's Signature** *Date*

**Parent should sign for a minor child.*

Non-Subscribers Only: Please read and sign the Authorization to Release below.

Authorization to Release. I hereby attest that by signing below I authorize MVP to release notice of my condition related to my vision and the related services and surgery associated with this reimbursement request to the subscriber (contract holder).

I understand all reimbursements up to the maximum will be made payable to the subscriber (contract holder) and mailed to the primary address on file for the subscriber.

*Patient's Signature** *Date*

**Parent should sign for a minor child.*

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.