Instructions for Submitting an Out-of-Network Claim

Getting Started

Confirm eligibility for out-of-network benefits by accessing the Member Information tab of the VBA Member Portal, or by contacting us. For more information about Out-of-Network claims and/or common reasons Out-of-Network claims may be denied, visit the FAQs on VBA's website.

What You'll Need

To submit a claim, you will need to provide us with a copy of your itemized, paid in full receipts or service statements with the following information:

- Provider's name;
- Patient's name;
- Date of service;
- Services and/or materials received; and
- Amounts paid.

Once you have collected the above documents, use the information to complete VBA's Out-of-Network Reimbursement Form.

VBA mails all reimbursement checks payable to the policyholder to the address listed on the policyholder's account in our system. If the address on your form is different from our system, you must correct the address with the policyholder's HR department.

Complete the Form

This form must be completed by the member. All fields with an asterisk (*) are required. This form is fillable, so you can complete electronically or print and handwrite.

Complete one form per member per date of service. If you received services and/or purchased materials from different providers, you must fill out a form for each provider.

How to Submit

After completing and signing the Out-of-Network Form, you may mail or fax your claim with copies of your itemized receipts to:

Mail: VBA, 400 Lydia Street, Suite 300, Carnegie, PA 15106
Fax: 412-881-4898

Go Green! For faster processing, you can submit your claim to VBA electronically. Simply use VBA's member login with the policyholder's information and select "Out-of-Network Claims." From there, follow the prompts to upload images of your signed forms and receipts.

Out-of-Network Forms must be submitted within 365 days of the date of service.

Keep a copy for your records.

Processing Your Claim

Please allow up to 30 days (after receipt) for VBA to process your reimbursement claim. If you submit incomplete documentation, a delay in reimbursement may occur. Sales tax and shipping fees are not reimbursable expenses.

All reimbursements will be sent to the policyholder's address submitted by the group.

When receipts are submitted for both contact lens materials and eyeglasses, VBA will process the claim for Eyeglasses unless otherwise specified.

Limited Access Area Exceptions

In remote or rural areas, occasionally geographic availability guidelines cannot be met. Additionally, there are instances when providers are not able to schedule within the 60-day timeframe. In these cases, VBA does not penalize the member and authorizes exceptions on behalf of members to visit out-of-network providers. Claims for these are processed at the in-network rate due to a provider's unavailability because of geographic area or lack of timeliness until a qualified provider in the member's area can be identified for contracting.

VBA determines the number of vision care providers that are required in certain geographic areas to serve the needs of members. Members who do not have access to an in-network provider within a 20-mile radius of their work or home may be approved for a Network Access Exception.

If a member is unable to schedule an appointment with a network provider, they should contact VBA Member Services prior to seeking treatment from an out-of-network provider prior to every claim submission. The customer care representative will note the system so that the member will receive in-network benefits.

Limited Access Area Exceptions do not apply when you choose an out-of-network provider due to your preference, your personal schedule not permitting you to schedule an appointment with an available provider or you are outside your home or office location.

Low Vision Aids

Low Vision Aids (LVA) are only reimbursable if your group has elected a LVA allowance and you submit a letter of medical necessity from your doctor.

The letter must be submitted with your Out-of-Network Form. LVA claims must meet VBA's criteria for low vision aids.

Medically Necessary Contact Lenses

Medically Necessary Contact (MNC) Lenses are only reimbursable if your group has elected a MNC allowance and you submit a letter of medical necessity from your doctor.

The letter must be submitted with your Out-of-Network Form. MNC claims must meet VBA's criteria for medically necessary contact lenses.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties

Out-of-Network Reimbursement Form

This form is only required if you received benefits from an out-of-network provider.

Claim*

I am submitting this OON form to be reimbursed for the following materials and/or services on:

☐ Vision Care Exam ☐ Eyeglasses ☐ Contact Lenses

☐ Low Vision Aids ☐ LASIK ☐ Medically Necessary Contact Lenses

Complete one form per member per date of service. If you received services and/or purchased materials from different providers, you must fill out a form for each provider. When receipts are submitted for both contact lens materials and eyeglasses, VBA will process the claim for Eyeglasses unless specified.

Policyholder

Last Name*		First Name*
Home Address*		
City*	State*	Zip*
Phone*		Email
Date of Birth (mm/dd/yyyy)*		Last 4 Digits of SSN #*
Group Name*		Group #

Patient

Relation to Policyholder (Choose One)*

☐ Policyholder ☐ Spouse ☐ Domestic Partner ☐ Child

Last Name	First Name
Date of Birth (mm/dd/yyyy)	

Provider

Last Name		First Name
Office Name*		
Address 1*		Address 2
City*	State*	Zip*

Signature*

By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information I have provided above is true and correct.

I acknowledge that without prior authorization for services rendered, I may be denied reimbursement for submitted vision care services for which I am not eligible. I hereby authorize any insurance company, organization employer, ophthalmologist, optometrist and optician to release any information with respect to this claim.

Signature	Date