MetLife | Vision VSP Choice Network

MyBenefits

Submit your out-of-network vision claim online

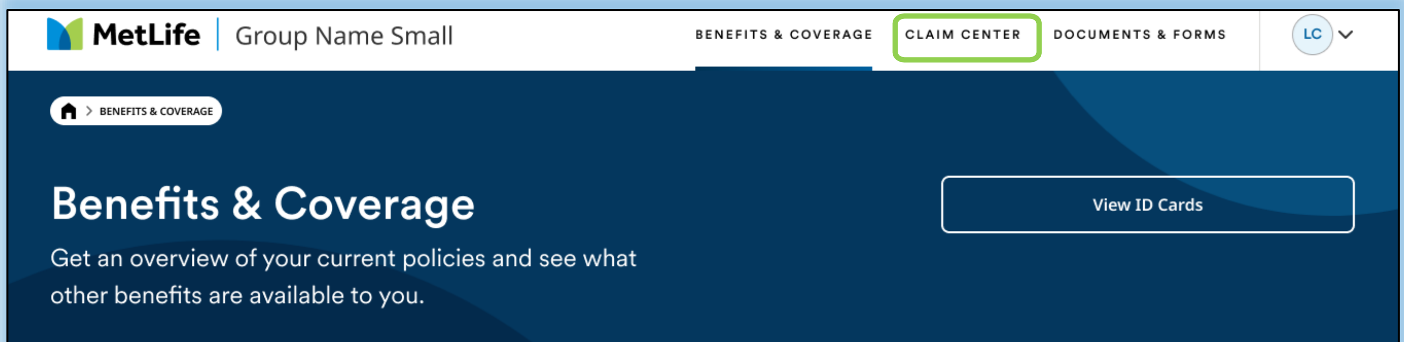
Use this MyBenefits online form to submit a claim for the following:

- Services rendered by an out-of-network provider.

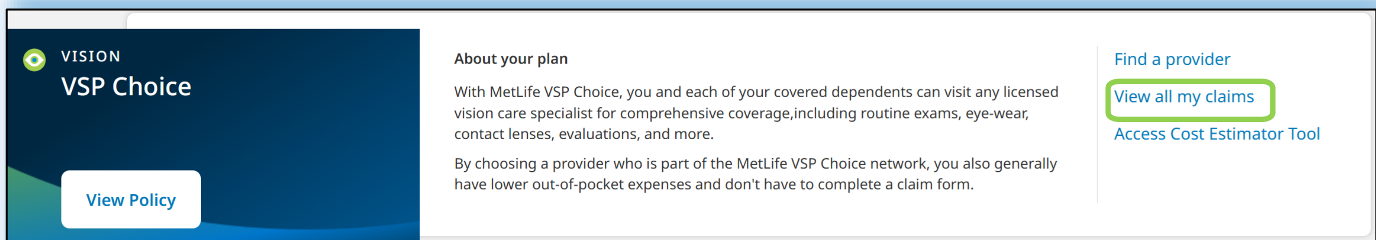
Before submitting a claim through MyBenefits, check with your provider to see if they can submit an out of network claim on your behalf.

Claims submitted here will be reimbursed according to your plan's **out-of-network rates**.

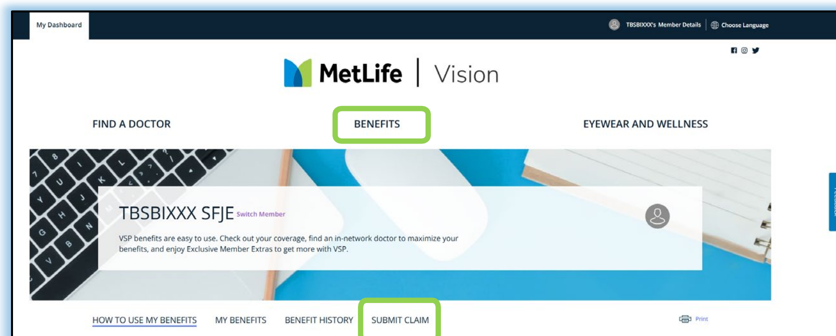
1. Once registered and logged in to **metlife.com/mybenefits**, from the Benefits & Coverage page click on the '**Claim Center**'.



2. From the Benefits & Coverage page, you can also click on '**View all my claims**' in the VSP Choice tile.



3. A new window will open. Under the **Benefits** tab, click on '**Submit Claim**'.



4. Next, click the link to the '**online form**' or the '**Continue**' button.

Requesting Your Reimbursement

If you have already visited an out-of-network vision provider, please follow the steps below to request reimbursement.

1. Click Continue to complete the online form.

   - OR -

   Download the form as a PDF in English or in Spanish. (Download Acrobat Reader)
2. Follow the directions and fill out the form in its entirety.
3. When finished with the online form, select "View and Print Form"
4. Complete a form for each patient and/or plan.
5. Verify information on form is correct, attach itemized receipts, and mail form and receipts to:

MetLife Vision
PO Box 495918
Cincinnati, OH 45249-5918

Important: *Requests for reimbursement must be submitted to MetLife within six months from the Date of Service.*

Please allow up to 10 business days (plus mailing time to and from MetLife) for us to process your reimbursement.

CONTINUE

5. An online form with 4 steps will appear. Enter all the applicable information, upload **itemized receipt(s)** and click **'Submit'**.

VSP Member Reimbursement Form

Step 1 of 4
Getting Started

What date did you receive services?

Date of Service/Purchase

Where did you receive services?

Doctor/Office Name/Location | Other Doctor/Office Name/Location | Address (Optional)

City (Optional) | State | Zip Code (Optional)

Doctor/Office/Location Phone (Optional)

Cancel | Continue

Step 2 of 4
Service Information

Edit

Step 3 of 4
Patient Information

Step 4 of 4
Receipt

Prefer to mail in a paper form with receipts?

You may also **download a form and mail it** to the address below. Follow the directions and fill out the form in its entirety.

- When finished with the form, select '**View and Print Form**'.
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P.O. Box 495918
Cincinnati, OH 45249-5918

Vision Insurance is provided by Metropolitan Life Insurance Company (MetLife), New York, NY. Certain claim and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with MetLife or its affiliates. Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details. VSP is a registered trademark of Vision Service Plan.

MetLife

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

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