

MyBenefits

Submit your out-of-network vision claim online



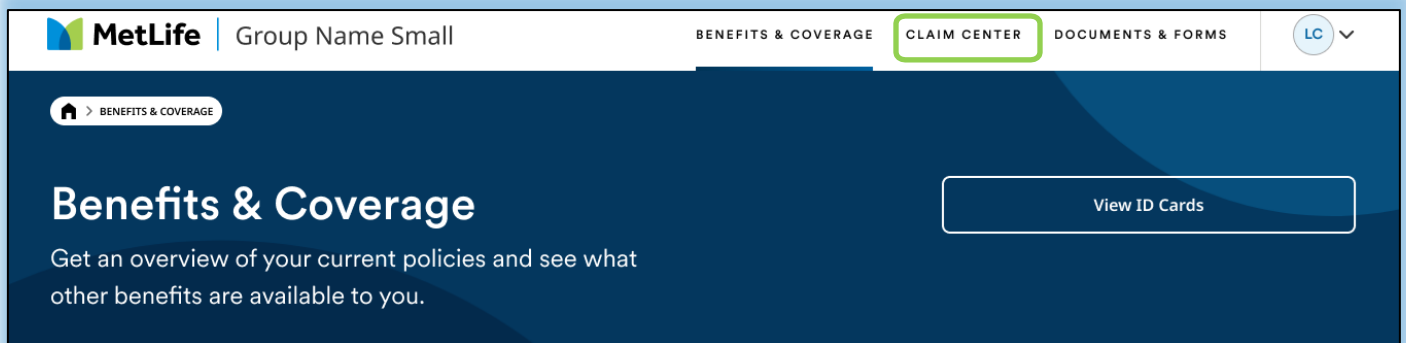
Use this MyBenefits online form to submit a claim for the following:

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

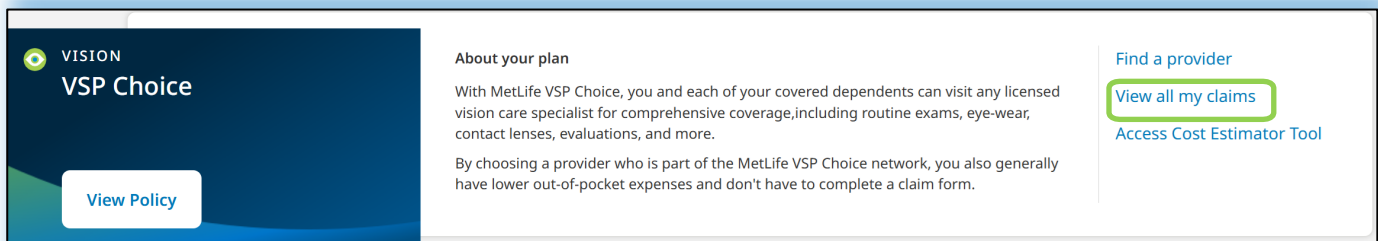
Before submitting a claim through MyBenefits, check with your provider to see if they can submit an out of network claim on your behalf.

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

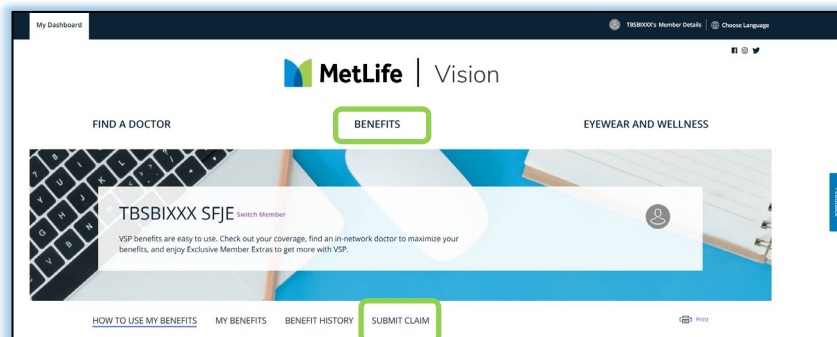
1. Once registered and logged in to metlife.com/mybenefits, from the Benefits & Coverage page click on the 'Claim Center'.



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'**.
- Complete a form for each patient and/or plan.

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CONTINUE

Verify the information on the form is correct, attach itemized receipts, and mail **form and receipts to:**

MetLife Vision
Attn: Claims Processing
P.O. Box 495918
Cincinnati, OH 45249-5918

FORM INSTRUCTIONS
The form must be filled out by the member. All fields flagged with an asterisk (*) are required. The form is fillable, so you do not have to hand write. Fill it out on a computer, print it, and mail it in. If you decide to hand write, use blue or black ink.

Patient section:

1. Select the patient's relation to the member. Choose only one.
2. Enter the patient's date of birth in the following format: Month/Day/Four-Digit Year
3. Select a gender. Choose only one.
4. Enter the patient's last name and first name.
5. Enter the address, city, state and ZIP code.
6. The patient's middle initial and ZIP+4 are optional.

Member section:

1. Enter the Last 4 Digits of the member's SSN.
2. If the patient is the member, select "Member information below is the same as Patient."
3. Otherwise, enter the member's information:

Claim section:

To request reimbursement, complete and print this form, enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.

METLIFE VISION MEMBER REIMBURSEMENT FORM

MetLife Vision
PO Box 495918
Cincinnati, OH 45249-5918

PATIENT

Relation to Member*: (choose one)
 Member Domestic Partner Dependent Parent Disabled Dependent
 Spouse Child Full-Time Student Other
 Date of Birth*: (mm/dd/yyyy) Gender*: Male Female
 Last Name*: First Name*: MI:
 Address*: State*: ZIP Code*: ZIP+4:
 City*: State*: ZIP Code*: ZIP+4:

MEMBER

Member information below is the same as Patient
 Last 4 Digits of SSN*: Gender*: Male Female
 Last Name*: First Name*: MI:
 Address 1*: Address 2*: City*: State*: ZIP Code*: ZIP+4:

CLAIM

Date of Service*: (mm/dd/yyyy) Another insurance company made payments to you, another insurer, or the doctor's office. If so, attach a copy of the statement showing payment.
 Exam: \$ Lens Type*: (choose one)
 Frame: \$ Single Progressive
 Lens: \$ Bi-focal Lenticular
 Lens tints or coatings: \$ Tri-focal
 Contact Lens Exam / Fitting Evaluation: \$
 Contacts: \$

PROVIDER

Last Name: First Name:
 Office Name:
 Address 1*: Address 2*: City*: State*: ZIP Code*: ZIP+4:

PRINT & SIGN

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 complete to the best of my knowledge. I acknowledge that the above-named provider is not a MetLife In-Network Vision Provider and that MetLife Vision cannot guarantee my eye care and/or eyewear satisfaction.

New York residents: 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 consents for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant Signature: _____ Date: _____

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.