SummaCare

Medicare Advantage Plan Claim Form for Vision Benefits

Member Name: (First, Middle, Last)	
Date of Birth: (month, day, year)	
Home Address: (street, city, state, zip)	
SummaCare Member ID Number: (refer to your SummaCare ID card)	
Telephone Number:	

Are any vision hardware expenses covered under another insurance? ___ Yes ___ No

If "Yes," complete the following. Name and address of company or organization:

_____

AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any physician, hospital, pharmacy, insurance company, employer, third party payer or organization to release any information regarding the history, treatment, or benefits payable concerning this claim to SummaCare. I certify that the information submitted by me is true and correct and I understand that falsifying a claim can lead to disciplinary action, including discharge.

Member signature:_____ Date:_____

Any Person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits fraudulent insurance act which is a crime.

You should receive your reimbursement within 30 days of submitting this form. SummaCare is an HMO and HMO-POS plan with a Medicare contract. Enrollment in SummaCare depends on contract renewal. If you have questions about this form, please call customer service at 330-996-8885 or (toll free) 800-996-6250 (TTY 800-750-0750). From October 1 through March 31, a representative is available to take your call 8 a.m. to 8 p.m., seven days a week. From April 1 through September 31, a representative is available to take your call 8 a.m. to 8 p.m., Monday through Friday.

Send your completed claim form and itemized bills to:
SummaCare Claims, PO Box 3620, Akron, Ohio 44309-3620