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:

Name: _____ **Address:** _____

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. I understand that falsifying a claim can lead to disciplinary action, including discharge.

Member signature: _____ **Date:** _____

Any person who knowingly intends to defraud an insurance company, and files a statement containing any materially false information or conceals information concerning any fact, commits a 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 Member Services at **330.996.8885** or (toll free) **800.996.6250** (TTY **711**). 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 30, 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
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