

**FOR INTERNAL USE ONLY:**

- Place of service: OF
- CPT Code: V2799
- Diagnosis Code: 367.89
- Tin: 0-069000010

**MEDICA®**



**MEDICA SOLO EYEWEAR CLAIM FORM**

This policy allows \$50 towards eyewear (glasses, frames, or contact lenses) per calendar year. If you pay for your eyewear at the time of purchase, please use this form to submit your claim.

**Send the completed form and copies of your receipts to:**

**Medica Individual Business Member Service  
Route CP 320  
PO Box 9310  
Minneapolis, MN 55440-9310**

If you have questions, please call Medica Customer Service at 952-992-1805 or 1-866-894-8051. Members with hearing impairments who have a TTY phone machine may call 952-992-3650 or toll-free at 1-800-234-8819.

| <b>To be completed by Policyholder: (Please Print)</b> |                          |
|--|--------------------------|
| Medica Policyholders Name:                             |                          |
| <input type="text"/>                                   |                          |
| Patient's Name:  | Patient's Date of Birth: |
| <input type="text"/>                                   | <input type="text"/>     |
| Medica Identification Number:                          |                          |
| <input type="text"/>                                   |                          |
| Date of Purchase:                                      |                          |
| <input type="text"/>                                   |                          |
| Home Telephone Number:                                 |                          |
| <input type="text"/>                                   |                          |
| Total Amount Paid for Eyewear:                         |                          |
| <input type="text"/>                                   |                          |
| Name of Vision Clinic or Provider:                     |                          |
| <input type="text"/>                                   |                          |
| Clinic Location (City, State, Zip):                    |                          |
| <input type="text"/>                                   |                          |