



MEDICA SOLOSM EYEWEAR CLAIM FORM
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Medica Solo 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.

(Please Print)

Medica Policyholders Name: _____

Patient's Name: _____ Patient's Date of Birth: _____

Medica Identification Number: _____ Home Telephone Number: _____

Date of Purchase: _____

Total Amount Paid for Eyewear: \$ _____

Name of Vision Clinic or Provider*: _____

Clinic Location:

City: _____ State: _____ Zip Code: _____

**Please note: If the provider is a contracted Medica provider, payment will be made to the provider. The provider is responsible for adjusting your account and forwarding any overpaid amount back to you.*

Internal Use Only:

Provider TIN _____

Dx: 367.89

Procedure Code: V2799