CATERPILLAR®
Policy Number: 100400
Caterpillar Customer Service # 866-CAT-4215

UnitedHealthcare®
United Healthcare
Medical Claims
PO Box 740800
Atlanta, GA 30374-0800

Caterpillar Routine Vision Claim Form

To help ensure correct and efficient payment of claims for routine vision services,

Please complete the **required** information on this form and review the following reminders:

- Is your Member # (Subscriber # or Alt ID) included on the form?
- Did you check the appropriate box or boxes for the item(s) or services you wish to have covered?
  - Indicate whether you are submitting a claim for an exam, glasses, or contacts by placing a check in the space in front of the code(s) and description(s).
- Did you complete all the provider information including Tax Identification number? Your provider's office can provide this number to you.
- Did you attach the receipt?
  - The receipt contains your name, the services and supplies purchased and name and address of the store or supplier.
  - Does the name on the receipt match the name on your UHC card? For example, Nate Smith will not be recognized if recorded at UHC as Nathan Smith. If your name does not match, please note the different name on the receipt.
- If the receipt does not have a price, also include the cash register receipt with the items to be reimbursed circled. It is important to note that for your claim to be processed appropriately, we must be able to match up the services with the amount paid. If your receipt does not have a price, an itemized cash register receipt is required.
- Please do not highlight or staple items together.

If you have any questions about the processes above, please contact UHC at (866) 228-4215.

UnitedHealthcare®
A UnitedHealth Group Company

Please complete all sections of this transmittal form. Claims *may* be delayed if all sections of this form are not completed. However, this does not guarantee that additional information will not be requested from you to process the claim. You will be advised in writing should additional information be required.

Vision Claim Form Transmittal for Caterpillar Inc.

Complete and Return this form via mail to:
United Healthcare Medical Claims
PO Box 740800
Atlanta, GA 30374-0800

Group Name	**Caterpillar Inc.**	Group Policy #	100400
Member Name		Member ID #	
Patient Name		Patient Relationship	
Patient Date of Birth		Member Phone #	
Member's Return Address	Street		
	Town/City		
	Zip code		

Eye Exam

Date of Exam: _____ Exam Fee $_____

Routine ophthalmological examination including refraction; new patient S0620 ☐
Routine ophthalmological examination including refraction; existing patient S0621 ☐
Optometrist/Ophthalmologist New Patient Exam 92004 ☐
Optometrist/Ophthalmologist Established Patient Exam 92014 ☐
Refraction Exam 92015 ☐

Lenses

Date of Purchase

Single Vision V2101-V2199 $ ☐ pair

Bifocals V2200-V2299 $ ☐ pair

Trifocal V2300-V2399 $ ☐ pair

Progressive V2781 $ ☐ pair

Contacts V2500 ☐ # of boxes

$ ☐ per box

Description of contact (daily, monthly, etc)

Frames

Date of Purchase ☐

V2020 $ ☐

V2025 $ ☐

DIAGNOSIS CODE: Z01.00

Provider Name: ☐

Tax ID # ☐

Street ☐

Town/City ☐

Zip code ☐

Section 3 – Pay to Information

PAY TO EMPLOYEE ONLY

Section 4 – Employee Signature - Signing this will verify that you have purchased the lenses or frames billed on the form above.

Name: _____ Date: _____