



**Duke University
Out of Network Claim form**

Today's Date		Date of Service	
Employee's Name		Employee's Social Security Number	
Address where check should be mailed (address, city, state, zip code)			
Patient's Name	Patient's Relationship to Employee	Patient's Birthdate	

Employee Signature

Date

MAIL OR FAX THIS FORM WITH A COPY OF YOUR PAID, ITEMIZED RECEIPT TO:

**Spectera Claims Department
PO Box 30978
Salt Lake City, UT 84130
Fax#: (248) 733-6060**

If you have any questions on your vision coverage, please call Spectera's Customer Service Department at (800) 638-3120.