OptiCare® Vision Plans

Member Claim Form
For Out of Network Services

Important: This form is intended for use by subscribers and covered dependents who receive services from providers outside of the OptiCare Vision Plan provider network. *<u>Please do not use this form to report services furnished by an in-network provider.</u>* No claim form is necessary for in-network services because the provider will submit the claim for you.

Instructions:

1. **Enter the requested information in the Patient Information and Subscriber Information sections.**
2. **Enter the name, address, and telephone number of the provider of service.**
3. **Print the form.**
4. **Sign and date the claim form**
5. **Attach a "Super Bill" or other itemized receipt which shows a breakdown of services and/or materials you received and mail to:**

   OptiCare Vision Plans
   P.O.Box 7548
   Rocky Mount, NC 27804

If you have any questions concerning completion of this form, please call (800) 368-4790 or email claimanswer@opticare.net

PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, MI)			PATIENT'S MEMBER ID NUMBER
PATIENT'S RELATIONSHIP TO SUBSCRIBER / EMPLOYEE:			**PATIENT'S DATE OF BIRTH**
☐SELF ☐SPOUSE ☐DEPENDENT			

SUBSCRIBER / EMPLOYEE INFORMATION

SUBSCRIBER / EMPLOYEE NAME (LAST, FIRST, MI)			SUBSCRIBER / EMPLOYEE DATE OF BIRTH

SUBSCRIBER / EMPLOYEE ADDRESS: If this is a new address, please check here ☐

HOUSE / APARTMENT NUMBER	STREET NAME

CITY	STATE	ZIP CODE

PROVIDER INFORMATION

PROVIDER'S NAME (LAST, FIRST)		PROVIDER'S ADDRESS (Address, City, State and Zip)			
		ADDRESS	CITY	STATE	ZIP

NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

When the Discounted Price on Materials Dispensed is less than the maximum benefit, insurance will pay the lesser amount (less Co-Pay). The undersigned hereby certifies the above-mentioned exam and materials were purchased on teh date of service stated above.

EMPLOYEE'S SIGNATURE	DATE:

To expedite your claim:

- **Please note that it is important that the documentation you attach identify the service(s) that were provided; therefore we are unable to accept copies of cancelled checks or "Balance Due" receipts.**
- **Please complete claim form in full.**
- **Don't forget to sign the claim form!**