



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. *Please do not use this form to report services furnished by an in-network provider.* 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: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	PATIENT'S DATE OF BIRTH

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. <input type="checkbox"/>		
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: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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 the claim form in full.
- Don't forget to sign the claim form!