

**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](mailto:claimanswer@opticare.net)

**PATIENT INFORMATION**

<b>PATIENT'S NAME (LAST, FIRST, MI)</b>		<b>PATIENT'S MEMBER ID NUMBER</b>	
<b>PATIENT'S RELATIONSHIP TO SUBSCRIBER / EMPLOYEE:</b>		<b>PATIENT'S DATE OF BIRTH</b>	
<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT			

**SUBSCRIBER / EMPLOYEE INFORMATION**

<b>SUBSCRIBER / EMPLOYEE NAME (LAST, FIRST, MI)</b>		<b>SUBSCRIBER / EMPLOYEE DATE OF BIRTH</b>	
<b>SUBSCRIBER / EMPLOYEE ADDRESS: If this is a new address, please check here <input type="checkbox"/></b>			
<small>HOUSE / APARTMENT NUMBER</small>		<small>STREET NAME</small>	
<small>CITY</small>	<small>STATE</small>	<small>ZIP CODE</small>	

**PROVIDER INFORMATION**

<b>PROVIDER'S NAME (LAST, FIRST)</b>		<b>PROVIDER'S ADDRESS (Address, City, State and Zip)</b>			
		<small>ADDRESS</small>	<small>CITY</small>	<small>STATE</small>	<small>ZIP</small>

**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.

<small>EMPLOYEE'S SIGNATURE</small>	<small>DATE:</small>

**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!