Out-of-Network Member Claim Form

Physicians Eyecare Plan

Today's Date ☐☐/☐☐/☐☐☐☐

Member ID # ☐☐☐☐☐☐☐☐☐

Primary Member Information: Please print clearly

Name ☐☐☐☐☐☐☐☐☐☐☐☐ (Last Name) ☐☐☐☐☐☐☐☐☐☐☐☐ (First Name) ☐ (MI)

Street Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐ Zip ☐☐☐☐☐

Date of Birth ☐☐/☐☐/☐☐☐☐ Telephone ☐☐☐-☐☐☐-☐☐☐☐

Patient Information: Please print clearly

Name ☐☐☐☐☐☐☐☐☐☐☐☐ (Last Name) ☐☐☐☐☐☐☐☐☐☐☐☐ (First Name) ☐ (MI)

Date of Birth ☐☐/☐☐/☐☐☐☐

Vision Claim: Please print clearly and list each service separately.

Date of Service:	Service: (e.g. Exam, Glasses or Contacts)	Amount Charged:
☐☐/☐☐/☐☐	☐☐☐☐☐☐☐☐☐☐☐☐	☐,☐☐☐.☐☐
☐☐/☐☐/☐☐	☐☐☐☐☐☐☐☐☐☐☐☐	☐,☐☐☐.☐☐
☐☐/☐☐/☐☐	☐☐☐☐☐☐☐☐☐☐☐☐	☐,☐☐☐.☐☐
☐☐/☐☐/☐☐	☐☐☐☐☐☐☐☐☐☐☐☐	☐,☐☐☐.☐☐

Provider's Name: _____ Telephone: (_____) _____

Providers Address: _____ City: _____ State: ____ Zip: _____

Physicians Eyecare Plan will only accept itemized paid receipts that indicate the services provided and the amount charged for each service. The services must be paid in full in order to receive benefits. Attach itemized paid receipts from your provider to the claim form and submit to:

Physicians Eyecare Plan,
Attn: Claims Department
48 Courtenay Drive
Charleston, SC 29403,

OR

Fax to: 843-577-5895

Member must submit claims within 6 months from date of service.

Employee Signature: _____ **Date:** _____