Out-of-Network Claim Form

This claim form is intended for use by employees and covered dependents enrolled in the Community Eye Care vision plan who obtain their benefit from an out-of-network provider. Please read the following instructions carefully:

1. Pay the provider for services rendered.
2. Enter all requested information below.
3. Attach the original itemized receipts. (Receipts must include Diagnosis & Procedure codes)
4. Sign and date the claim form.

Mail the completed claim form to: Community Eye Care
Attn: Out-of-Network Claims
2359 Perimeter Pointe Parkway, Suite 150
Charlotte, NC 28208

Please call 1-888-254-4290 with any questions concerning this claim form or with any questions concerning reimbursement.

PATIENT INFORMATION *(Required if different than the employee)*

Last Name	First Name		Birth Date	
Street Address	City	State	Zip Code	Telephone #

EMPLOYEE INFORMATION *(Required)*

Last Name	First Name		Employee ID#	
Street Address	City	State	Zip Code	Telephone #
Birth Date	Employer's Name			

PROVIDER / OPTICAL INFORMATION *(Required)*

Provider Name			Telephone #
Street Address	City	State	Zip Code

Patient's or Authorized Person's Signature: By signing below, I authorize the release of any medical or other information necessary to process this claim.

Signed ____ Date ______________________