Out-of-Network Claim Form

You only need to complete this form if, *at the time of service*, the provider did **NOT** participate in the Community Eye Care network. For questions about reimbursement, please call 1-888-254-4290.

HOW TO FILE AN OUT-OF-NETWORK CLAIM

- Complete all applicable fields on this form. Missing information may delay processing and payment.
- Submit one claim form for each patient to Community Eye Care within 180 days of the date of service.
- Please submit a copy of your itemized receipt for each service or product included on this claim form.
- This form must be signed by the patient or his/her authorized representative.
- You have a choice of three options for submitting the completed form:

FAX
704-426-6044

MAIL
Community Eye Care
Attn: Out-of-Network Claims
2359 Perimeter Pointe Parkway, Suite 150
Charlotte, NC 28208

EMAIL
claims@communityeyecare.net

PATIENT AND EMPLOYEE INFORMATION

Patient First and Last Name:

Patient Date of Birth:

Employee First and Last Name:

Patient Relationship to Employee:
☐ Self ☐ Dependent

Employee Mailing Address:

Employee Phone #:

Employer:

Employee's Member ID#:

REQUEST FOR REIMBURSEMENT — PLEASE CHECK ALL THAT APPLY

Date of service(mm/dd/year): _____

☐ **Eye/Vision Exam . . . Amount Paid: $** _____

Date of service (mm/dd/year): _____

☐ **Contact Lens Fit/Evaluation . . . Amount Paid: $** _____

COMPLETE BELOW FOR GLASSES

Date of service(mm/dd/year): _____

☐ **Frames for glasses . . . Amount Paid: $** _____

☐ **Lenses for glasses . . . Amount Paid: $** _____

LENS TYPE (check only one)
☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Progressive

COMPLETE BELOW FOR CONTACTS

Date of service(mm/dd/year): _____

☐ **Contact Lenses . . . Amount Paid: $** _____

IMPORTANT: Please remember to submit a copy of your itemized receipt for each service or product included on this claim form.

PROVIDER OR OPTICAL INFORMATION

Name of Provider/Optical:

Phone # of Provider/Optical:

Address of Provider/Optical:

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.

Signature _____ Date _____