OptiCare
MANAGED VISION

Member Claim Form for Routine Vision

Important: This form is intended for use by members who receive services from providers outside of the OptiCare Managed Vision provider network. Please do not use this form to report services furnished by an OptiCare provider. No claim form is necessary because the provider will submit the claim for you.

Instructions:

1. Enter the requested information in the Member Information section.
2. Enter the requested information in the Provider Information section.
3. Print the form, if applicable.
4. Sign and date the claim form.
5. Attach a "super bill" or other itemized receipt which shows a breakdown of services and/or eyewear you received and mail to:

   OptiCare Managed Vision
   P.O. Box 7548
   Rocky Mount, NC 27804

If you have any questions concerning completion of this form, please call 1-866-921-7963.

MEMBER INFORMATION				
NAME (LAST, FIRST, MI)			DATE OF BIRTH	UPMC *for Life* ID #
ADDRESS: If this is a new address, please check here. ☐				
STREET ADDRESS				
CITY	STATE	ZIP CODE	PHONE NUMBER	

PROVIDER INFORMATION			
NAME	STREET ADDRESS		
CITY	STATE	ZIP CODE	PHONE NUMBER

NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties**.**

MEMBER'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 claim form in full.**
- **Please remember to sign the claim form.**