



## 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. 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.
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			ID#
Mailing 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 \_\_\_\_\_