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 for and submit to:

Physicians Eyecare Plan
Attn: Claims Department
2170 Ashley Phosphate Rd., Ste 604
North Charleston, SC 29406

OR

Fax: 843-577-5895

Email: info@pepvision.com

Member must submit claims within 90 days from date of service.

Employee Signature: _____ **Date:** _____