Physicians Eyecare Plan

Member Claim Form

The Quality Vision Program for South Carolina

Patients Name: _____ Sex: ☐ Male ☐ Female

Patients Birthdate: _____/_____/_____

Patients Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: _____

Insured's ID Number: _____

Patients Address: _____

City: _____ State: _____ Zip: _____ Telephone: (____) _____

DATE OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT PAID

Provider's Name: _____

Providers Address: _____

City: _____ State: _____ Zip: _____ Telephone: (____) _____

If you choose to use an out-of-network provider, Physicians Eyecare Plan will reimburse you according to the schedule shown below. Please include a copy of your itemized receipts to: Physicians Eyecare Plan, 48 Courtenay Drive, Charleston, SC 29403, Attn: Claims Department or fax to (843) 577-5895.

Exam including contact lens fitting: $40
Material Benefit: 65% of the used allowable material benefit.

Any out-of-network purchases are to be paid in full to the out-of-network provider at the time of service. Member must submit claims within 60 days of receiving the out-of-network service.