

OPTICARE CLAIM STATUS FORM

Please return to fax# (800) 980-4002

Please allow 1 week for response.

Please note: Claims must be 45 days old to status.

From: _____

Telephone #: (_____) _____

Fax #: (_____) _____

Member Name	Member ID #	Date of Birth	Date of Service	CPT Code(s)	(please circle one)	(OptiCare Use Only)	(OptiCare Use Only) Comments
					How was claim submitted?	Status Code	
					Mailed EDI (electronic) Web		
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STATUS CODES:

S1: CLAIM RECEIVED AND IS IN PROCESS.

S2: CLAIM PREVIOUSLY PAID. NOTE EOB DATE.

S3: CLAIM PREVIOUSLY DENIED. NOTE EOB DATE.

S4: MEMBER CAN NOT BE LOCATED IN OPTICARE'S SYSTEM.

S5: OTHER, SEE NOTE

Date Status Completed: _____