



Association of Eye Care Centers Total Vision Health Plan, INC
AECC Total Vision Health Plan of Texas, INC.

OptiCare Managed Vision
Claim Appeal Request Form
(One claim appeal per form)

Claim appeals may be filed with OMV in order to challenge any adverse determination. Appeals must be filed within plan specific days. Please consult your Office Staff Guide (Section 6). For all claim appeals, please **PRINT OR TYPE** this form in full; attach the appropriate documents and mail to:

OptiCare Managed Vision
Attn: Appeals Department
P.O. Box 7548
Rocky Mount, NC 27804

Today's Date: _____

Provider Name: _____

Practice Name _____

Claim Information:

Patient ID Number: _____ Date of Service: _____

Patient Name: _____ Service(s) Provided (CPT): _____

HealthPlan Name: _____ OMV Claim #: _____

Request for Review: Indicate the reason(s) this claim should be reconsidered.

The below attachments are required, if applicable:

1. Claim specific correspondence from OMV (authorizations, referrals, Primary EOB, etc).
2. Documentation supporting the appealed claim (operative reports, medical records, chart notes, etc).
3. A copy of the CMS/HCFA 1500 listing the appealed claim.
4. A copy of the OMV EOB in which this claim is listed.