Out-of-Network Claim Form Instructions

IMPORTANT INFORMATION

Please read before submitting your out-of-network claim form.

To submit your out-of-network claim form online, please visit **www.cecvision.com/oonform**.

Reimbursements are processed within 30-days from the date we receive your out-of-network claim form.

HOW TO FILE AN OUT-OF-NETWORK CLAIM

- Complete all applicable fields on this form, including the signature. Missing information may delay processing and reimbursement.
- Submit one claim form for each patient to CEC within 180 days of the date of service.
- Submit a copy of your itemized receipt for each service or product included on this claim form.
- Mail your completed form and receipt(s) to:

  Community Eye Care (CEC)
  Attn: Out-of-Network Claims
  4944 Parkway Plaza Blvd, Suite 200
  Charlotte, NC 28217

Out-of-Network Claim Form

PATIENT INFORMATION — Details of the person who received the service

Patient First and Last Name: Patient's Relationship to Employee: ☐ Self ☐ Dependent	Patient Date of Birth:

PRIMARY MEMBER INFORMATION — Employee

Employee First and Last Name: Employer Name:	Date of Birth: Member ID#:

CONTACT AND MAILING INFORMATION — Where the reimbursement check should be mailed

Mailing Address:	Phone Number: Email Address:

REQUEST FOR REIMBURSEMENT — PLEASE CHECK ALL THAT APPLY

Date of service(mm/dd/year): ____________________ ☐ **Eye/Vision Exam** .... Amount Paid: $ ____________________	Date of service (mm/dd/year): ____________________ ☐ **Contact Lens Fit / Evaluation** Amount Paid: $ _____
COMPLETE BELOW FOR GLASSES Date of service(mm/dd/year): ____________________ ☐ Lenses for glasses .... Amount Paid: $ ____________________ ☐ Frames for glasses .... Amount Paid: $ ____________________ ☐ Non-prescription sunglasses ..... Amount Paid: $____________________ **LENS TYPE** (check only one) ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Progressive ☐ Non-prescription	**COMPLETE BELOW FOR CONTACTS** ☐ Date of service(mm/dd/year): ____________________ ☐ Contact Lenses .... Amount Paid: $____________________

PROVIDER OR OPTICAL INFORMATION

Name of Provider/Optical: Address of Provider/Optical:	Phone # of Provider/Optical:

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. I have read and agree to CEC's policies for out-of-network claims outlined on page one of this document.*

Signature____________________________________ Date ____________________

For questions about your out-of-network reimbursement, please call 1-888-254-4290 (Option 1 and then Option 2).

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