CPSOPTICAL

NOITU

Out of Network Claim Form

CPS USE ONLY
V #:

PATIENT INFO

INSURED NAME (Last Name, First Name)	PATIENT NAME (Last Name, First Name)	9 CHARACTER MEMBER NTU ID (Example: NTU123456)
ADDRESS CITY STATE ZIP	PATIENT DATE OF BIRTH	RELATIONSHIP TO MEMBER ☐ Self ☐ Spouse ☐ Dependent

I acknowledge receiving the services specified below. I authorize release of any information related to this claim to the Plan and/or Claims Administrator of this Vision Care Plan. Any allowable or covered benefits will be reimbursed to the insured.

PATIENT'S SIGNATURE: _____ DATE: _____

EXAM

DATE OF SERVICE:	SERVICE RENDERED: ☐ Regular Eye Exam ☐ Contact Lens Fitting	EXAM FEE PAID $
PROVIDER'S NAME ADDRESS CITY STATE ZIP		TELEPHONE NO. Area Code ( )

MATERIALS

FRAME NAME: _____ Retail $ _____

LENS TYPE	Retail	OPTIONS	Retail		Retail	CONTACTS	Retail
☐ Single Vision	$_____	☐ Polycarbonate	$_____	☐ Tint	$_____	☐ Daily Wear	$_____
☐ Bifocal	$_____	☐ Transitions	$_____	☐ Hi-Index	$_____	☐ Disposable	$_____
☐ Trifocal	$_____	☐ Scratch Coating	$_____	☐ A/R Coating	$_____	☐ Other	$_____
☐ Progressives	$_____	☐ Ultra-Violet Coating	$_____	☐ Other	$_____		
☐ Safety	$_____						
☐ Other	$_____						

DO NOT MARK IN THIS BOX

EXAM	$_____
FRAME	$_____
LENSES	$_____
CONTACTS	$_____
OTHER	$_____
TOTAL BILLED	$_____

THIS FORM MUST BE COMPLETED AND RETURNED WITH A PAID ITEMIZED RECEIPT.

MAIL CLAIM TO:

COMPREHENSIVE PROFESSIONAL SYSTEMS INC.
11 HANOVER SQUARE, 8TH FLOOR
NEW YORK, NY 10005
(212) 675-5745

12/2016