CONED RETIREES

Vision Care Out of Network Claim Form

CPSOPTICAL

CPS USE ONLY
V #:

GROUP MUST BE CHECKED:

☐ **UNION RETIREE**

☐ **MANAGEMENT RETIREE**

PATIENT INFO

INSURED NAME (Last Name, First Name)	PATIENT NAME (Last Name, First Name)	5 DIGIT CE EMPLOYEE ID (or Insured's SSN)
ADDRESS CITY STATE ZIP	PATIENT DATE OF BIRTH	RELATIONSHIP TO MEMBER ☐ Self ☐ Spouse ☐ Dependent
PATIENT'S SIGNATURE: _____		DATE: _____

EXAM

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

RX REQUIRED

DATE ORDERED		Sphere	Cylinder	Axis	Prism	Add
	R					
	L					

If RX changed after 12 months, provider must add the previous RX below.

DATE ORDERED		Sphere	Cylinder	Axis	Prism	Add
	R					
	L					

MATERIALS

FRAME NAME/MODEL#: _____ **Retail $** _____

LENS TYPE	Retail	OPTIONS	Retail	CONTACTS	Retail
☐ Single Vision	$_____	☐ Polycarbonate	$_____	☐ Hard	$_____
☐ Bifocal	$_____	☐ Scratch Coating	$_____	☐ Soft	$_____
☐ Trifocal	$_____	☐ Ultra-Violet Coating	$_____	☐ Daily Wear	$_____
☐ Standard Progressive	$_____	☐ Tint	$_____	☐ Extended Wear	$_____
		☐ A/R Coating	$_____	☐ Disposable	$_____
		☐ Other	$_____		

DO NOT MARK IN THIS BOX

EXAM $_____

FRAME $_____

LENSES $_____

CONTACTS $_____

OTHER $_____

TOTAL BILLED $_____

LOCATION WHERE SERVICE WAS PROVIDED:

Store Name:

Address:

Phone Number: ( ) _____

MAIL CLAIM TO:

COMPREHENSIVE PROFESSIONAL SYSTEMS INC.
11 HANOVER SQUARE, 8TH FLOOR
NEW YORK, NY 10005