



CPSOPTICAL

# NOITU

## Out of Network Claim Form

<b>CPS USE ONLY</b>
V #:

P A T I E N T	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
I N F O	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: _____	

E X A M	DATE OF SERVICE:	SERVICE RENDERED: <input type="checkbox"/> Regular Eye Exam <input type="checkbox"/> Contact Lens Fitting	EXAM FEE PAID <b>\$</b>		
	PROVIDER'S NAME	ADDRESS	CITY	STATE	ZIP

M A T E R I A L S	FRAME NAME: _____ Retail \$ _____			<b>DO NOT MARK IN THIS BOX</b>	
	LENS TYPE Retail	OPTIONS Retail	CONTACTS Retail	EXAM	\$ _____
<input type="checkbox"/> Single Vision \$ _____	<input type="checkbox"/> Polycarbonate \$ _____	<input type="checkbox"/> Tint \$ _____	<input type="checkbox"/> Daily Wear \$ _____	FRAME	\$ _____
<input type="checkbox"/> Bifocal \$ _____	<input type="checkbox"/> Transitions \$ _____	<input type="checkbox"/> Hi-Index \$ _____	<input type="checkbox"/> Disposable \$ _____	LENSES	\$ _____
<input type="checkbox"/> Trifocal \$ _____	<input type="checkbox"/> Scratch Coating \$ _____	<input type="checkbox"/> A/R Coating \$ _____	<input type="checkbox"/> Other \$ _____	CONTACTS	\$ _____
<input type="checkbox"/> Progressives \$ _____	<input type="checkbox"/> Ultra-Violet Coating \$ _____	<input type="checkbox"/> Other \$ _____		OTHER	\$ _____
<input type="checkbox"/> Safety \$ _____				TOTAL BILLED	\$ _____
<input type="checkbox"/> Other \$ _____					

<b>THIS FORM MUST BE COMPLETED AND RETURNED WITH A PAID <u>ITEMIZED</u> RECEIPT.</b>	<b>MAIL CLAIM TO: COMPREHENSIVE PROFESSIONAL SYSTEMS INC. 11 HANOVER SQUARE, 8TH FLOOR NEW YORK, NY 10005 (212) 675-5745</b>
--	--