Out-of-Network Claim Form (OON)

CEC community eye care

You only need to complete this form if, at the time of service, the provider did NOT participate in the CEC network.

HOW TO FILE AN OUT-OF-NETWORK CLAIM

- Complete all applicable fields on this form. Missing information may delay processing and reimbursement.
- Submit one claim form for each patient to CEC within 180 days of the date of service.
- Please submit a copy of your itemized receipt for each service or product included on this claim form.
- This form must be signed by the patient or his/her authorized representative.
- You have a choice of three options for submitting the completed form:

eFAX	MAIL	EMAIL
1(704)413-7098	CEC Attn: Out-of-Network Claims 2359 Perimeter Pointe Parkway, Suite 150 Charlotte, NC 28208	OON@cecvision.com

PATIENT INFORMATION — Details of the person who received the service

Patient First and Last Name: Patient Date of Birth:

Patients Relationship to Employee: ☐ Self ☐ Dependent Member ID#:

PRIMARY MEMBER INFORMATION — Employee

Employee First and Last Name: Date of Birth:

Employer Name: Member ID#:

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

Employee Mailing Address:

Email Address: Phone #:

REQUEST FOR REIMBURSEMENT — PLEASE CHECK ALL THAT APPLY

Date of service(mm/dd/year): _____ Date of service (mm/dd/year): _____

☐ **Eye/Vision Exam . . . Amount Paid: $** _____ ☐ **Contact Lens Fit/Evaluation . . . Amount Paid: $** _____

COMPLETE BELOW FOR GLASSES

Date of service(mm/dd/year): _____

☐ **Frames for glasses . . . Amount Paid: $** _____

☐ **Lenses for glasses . . . Amount Paid: $** _____

LENS TYPE (check only one)

☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Progressive

COMPLETE BELOW FOR CONTACTS

Date of service(mm/dd/year): _____

☐ **Contact Lenses . . . Amount Paid: $** _____

IMPORTANT: Reimbursements are processed within 60 days from the date we receive your Out-of-Network claim form. For questions about your Out-of-Network reimbursement, please call 1-888-254-4290 (Option 2 and then Option 1).

PROVIDER OR OPTICAL INFORMATION

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

Address 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.

Signature _____ Date _____