



Paper Out-of-Network Claim Form Instructions

IMPORTANT INFORMATION

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

- 1 This form is only for mailing out-of-network claims to CEC. If you prefer to submit your out-of-network claim form online, please visit www.cecvision.com/oonform. Claims submitted online are processed within 30 days.
- 2 Reimbursements are processed within **60 days** from the date we receive your paper out-of-network claim form.
- 3 Out-of-network claims for services and/or eyewear obtained from an *in-network* provider will **not** be reimbursed.

CEC understands that vision plan members may encounter sales promotions (such as “two-for-one sales”) or steep discounts offered by some of our optical providers. As is true of most vision plans, your CEC vision plan is not intended for use in conjunction with these types of offers. In general, providers will allow only one of the following:

- The CEC vision benefit, or
- The sales promotion (the sale price or discount)

HOW TO FILE AN OUT-OF-NETWORK CLAIM

- Complete this form if, at the time of service, the provider did NOT participate in the CEC network.
- 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:

CEC
Attn: Out-of-Network Claims
2359 Perimeter Pointe Parkway, Suite 150
Charlotte, NC 28208



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: <input type="checkbox"/> Self <input type="checkbox"/> Dependent	Patient Date of Birth:
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PRIMARY MEMBER INFORMATION — Employee

Employee First and Last Name: Employer Name:	Date of Birth: Member ID#:
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CONTACT AND MAILING INFORMATION — Where the reimbursement check should be mailed

Mailing Address:	Phone Number: Email Address:
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REQUEST FOR REIMBURSEMENT — PLEASE CHECK ALL THAT APPLY

Date of service(mm/dd/year): _____ <input type="checkbox"/> Eye/Vision Exam Amount Paid: \$ _____	Date of service (mm/dd/year): _____ <input type="checkbox"/> Contact Lens Fit / Evaluation Amount Paid: \$ _____
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<p style="text-align: center;">COMPLETE BELOW FOR GLASSES</p> Date of service(mm/dd/year): _____ <input type="checkbox"/> Lenses for glasses Amount Paid: \$ _____ <input type="checkbox"/> Frames for glasses Amount Paid: \$ _____ <input type="checkbox"/> Non-prescription sunglasses Amount Paid: \$ _____ LENS TYPE (check only one) <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Progressive <input type="checkbox"/> Non-prescription	<p style="text-align: center;">COMPLETE BELOW FOR CONTACTS</p> <input type="checkbox"/> Date of service(mm/dd/year): _____ <input type="checkbox"/> Contact Lenses Amount Paid: \$ _____
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PROVIDER OR OPTICAL INFORMATION

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