Comprehensive Professional Systems Inc.

Consolidated Edison Orange & Rockland

Vision Care Out of Network Claim Form

CPS USE ONLY
V #:

PLAN NAME: _____

PATIENT INFO

INSURED NAME (Last Name, First Name)	PATIENT NAME (Last Name, First Name)	INSURED SOCIAL SECURITY NUMBER
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 ☐ Fitting	NORMAL EXAM FEE $
PROVIDER'S NAME ADDRESS CITY STATE ZIP		TELEPHONE NO. Area Code ( )

MATERIALS

DATE ORDERED:		Sphere	Cylinder	Axis	Priam	Add
	R					
	L					

FRAME NAME: _____ Retail $ _____

DO NOT MARK IN THIS BOX

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

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