



Out-of-Network Claim Form Instructions

IMPORTANT INFORMATION

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

To submit your out-of-network claim form online, please visit
www.cecvision.com/oonform.

Reimbursements are processed within 30 business days from
the date we receive your out-of-network claim form.

HOW TO FILE AN OUT-OF-NETWORK CLAIM

- 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 365 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:
Community Eye Care (CEC)
Attn: Out-of-Network Claims
PO Box 997100
Sacramento, CA 95899



Out-of-Network Claim Form

PATIENT INFORMATION — Details of the person who received the service	
Patient First and Last Name:	Patient Date of Birth:
Patient's Relationship to Employee: ☐ Self ☐ Dependent	
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	
Mailing Address:	Phone Number:
	Email Address:
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	COMPLETE BELOW FOR CONTACTS
Date of service(mm/dd/year): _____	☐ Date of service(mm/dd/year): _____
☐ Lenses for glasses Amount Paid: \$ _____	☐ Contact Lenses Amount Paid: \$ _____
☐ Frames for glasses Amount Paid: \$ _____	
☐ Non-prescription sunglasses Amount Paid: \$ _____	
LENS TYPE (check only one)	
☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Progressive ☐ Non-prescription	
PROVIDER OR OPTICAL INFORMATION	
Name of Provider/Optical:	Phone # of Provider/Optical:
Address of Provider/Optical:	
Patient's or Authorized Person's Signature: <i>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.</i>	
Signature _____ Date _____	

For questions about your out-of-network reimbursement, please call 888-254-4290