PROFESSIONAL EYE CARE ADMINISTRATORS, INC.

Benefit Claim Form

Employee Full Name _____ Last (4) SSN _____
LAST FIRST MI

Address: _____
STREET CITY STATE ZIP

Employer Name: _____ Plan # _____

Patient Name: _____ DOB: _____
LAST FIRST MI

I understand that the claim being filed is for a direct-payment benefit plan provided by my employer. I also understand that I am responsible for all charges not covered by my employer less the benefit discounts I receive by obtaining services from this participating provider. If this is an out-of-network claim, I understand a $15.00 processing fee will be deducted from my direct reimbursement.

Patient Signature: X _____ Date: _____

Services Provided:

___ In-Network Claim ___ Out-of-Network Claim

Exam Services:

Date of Service: _____ **Total Exam Charges:** _____

Was the $10 copayment collected from the patient? _____

Materials Benefits: Amount expected from employer's benefit plan: _____

Date of Service: _____

Total Frame Amount (before discounts): _____

Total Eyeglass Lens Amount (before discounts): _____

Indicate lens type: ____ SVO _____ BF _____TF _____ PAL

Total Contact Lens Amount (fitting fee included): _____

Total Materials Amount (after discounts): _____

Provider Name: _____ **TIN #:** _____

Address/Phone of Location where Services Provided: _____

_____

Signature of Provider: X _____ Date: _____

**Send completed claim form to: PECA, Inc., PO Box 32, Edinboro, PA 16412 or Fax: (814) 734-9207.
All claim and eligibility questions should be directed to PECA, Inc. at (814) 734-3062.