CS EYE/PEN BILLING DEPARTMENT CLAIMS RESEARCH FORM

COMPLETE ALL FIELDS AND FAX TO **888-898-2102**

PLEASE ALLOW UP TO **3 BUSINESS DAYS** FOR RESEARCH AND RESPONSE IF REQUESTED

CLINIC NAME _____ PEN ID# _____ CONTACT NAME _____

PHONE _____RESPONSE NEEDED BY: ☐ CALL BACK ☐ FAX INFO ☐ NO RESPONSE NEEDED

1 FIRST NAME _____ LAST NAME _____ DOB _____

DOS _____ RESEARCH NEEDED _____

2 FIRST NAME _____ LAST NAME _____ DOB _____

DOS _____ RESEARCH NEEDED _____

3 FIRST NAME _____ LAST NAME _____ DOB _____

DOS _____ RESEARCH NEEDED _____

4 FIRST NAME _____ LAST NAME _____ DOB _____

DOS _____ RESEARCH NEEDED _____

5 FIRST NAME _____ LAST NAME _____ DOB _____

DOS _____ RESEARCH NEEDED _____

6 FIRST NAME _____ LAST NAME _____ DOB _____

DOS _____ RESEARCH NEEDED _____

7 FIRST NAME _____ LAST NAME _____ DOB _____

DOS _____ RESEARCH NEEDED _____

8 FIRST NAME _____ LAST NAME _____ DOB _____

DOS _____ RESEARCH NEEDED _____

PLEASE NOTE OUR PORTAL IS AVAILABLE 24/7 TO VIEW CLAIM STATUS AND EOB'S
FOR INSTRUCTIONS OR ADDITIONAL FORMS, PLEASE VISIT **WWW.CSEYE.BIZ/PENBILLING**