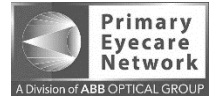




CS EYE/PEN BILLING DEPARTMENT CLAIMS RESEARCH FORM



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](http://WWW.CSEYE.BIZ/PENBILLING)