UECP Member Update

Primary Owner/OD Name:_____

Email address:_____ (for UECP business)

Locations (Practice Name, address, state, zip and phone)

1._____

2._____

3._____

4._____

5._____

Associate OD's (name and email address for product info, classes, trainings, industry info)

1._____

2._____

3._____

4._____

5._____

6._____

Do you have a compliance manual or written policies and procedures? Yes No

PERC Member (please circle) YES NO

Any other doctor alliance group currently belong to: _____

Current Contact Lens Distributor: _____ Contact Lens of Choice:_____

Current Spectacle Lab: _____ Lens/Brand of Choice: _____

Medical:

Do you currently bill medical insurance companies for medical services? YES NO

IF so, which plans (circle): BCBS Aetna Cigna Humana UHC MultiPlan Medicare

Billing company: _____ Internal billing: YES NO

Would you like to bill more medical? YES NO If yes, any specific plans: _____

Do you have an EMR/EHR system? Yes No if yes, which_____

What is holding you back from billing more medical:

_____

_____

Social Media:

Website:_____

FB page Instagram Twitter Other:_____

Do you access the UECP Portal for sales aids, info, marketing, etc YES NO

What improvements or services would you like to see from UECP?:

_____

_____

Are you Interested in coming to our Nov 1st CE?; YES NO

How can we continue to support you?:

_____

_____

Additional comments/suggestions:

_____

_____

_____

_____

PLEASE EMAIL TO: info@uecp.com or FAX TO: (630) 243-7123