Please forward claims to:

MESVision

Medical Eye Services

PO Box 25209 • Santa Ana, CA 92799-5209

(800) 877-6372 (714) 619-4660 TTY/TDD (877) 735-2929

www.MESVision.com

The Participating Provider Must Call MESVision to obtain an Eligibility Verification Number

CLAIM SUBMITTED FOR: EXAM ONLY ☐ MATERIALS ONLY ☐ EXAM & MATERIALS ☐

PART 1. TO BE COMPLETED AND SIGNED BY THE INSURED
PLEASE USE BLACK INK ONLY!

PATIENT'S NAME (Last Name, First)	SEX (PLEASE CIRCLE) MALE ☐ FEMALE ☐	EMPLOYEE'S IDENTIFICATION NO.
EMPLOYEE'S NAME	RELATIONSHIP TO EMPLOYEE SELF ☐ SPOUSE ☐ CHILD ☐	PATIENT'S BIRTHDATE MONTH DAY YEAR
STREET ADDRESS	NAME OF EMPLOYER	GROUP POLICY NUMBER
CITY, STATE, and ZIP CODE		

OTHER VISION COVERAGE? IF "YES," GIVE NAME OF CARRIER AND POLICY NUMBER YES ☐ NO ☐	WAS CARE REQUIRED BECAUSE OF AN INJURY OR ILLNESS? YES ☐ NO ☐ IF "YES," PLEASE EXPLAIN:
IF DEPENDENT AGE OVER CONTRACT AGE LIMIT, ARE THEY A FULL-TIME STUDENT? YES ☐ NO ☐	STUDENT'S ID NUMBER / NAME OF SCHOOL:

CHECK CONDITION(S) PATIENT IS KNOWN TO HAVE: DIABETES ☐ DIABETIC RETIN ☐ HYPERTENSION ☐ GLAUCOMA ☐ ARMD ☐ ARCUS ☐ NONE ☐

The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize my doctor to furnish and disclose all facts concerning this claim. I hereby assign payable benefits to participating providers.

SIGNATURE _____ DATE _____

PART 2. TO BE COMPLETED BY DOCTOR
PLEASE USE BLACK INK ONLY!

DATE OF EXAMINATION	REFRACTION / NO REFRACTION

IF YOU PRESCRIBED GLASSES, CHECK ALL THAT APPLY

SNGL VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ PROGRESSIVE ☐ CONTACTS ☐

HAS CATARACT SURGERY BEEN PERFORMED YES ☐ NO ☐ DATE:

HAS LASIK SURGERY BEEN PERFORMED YES ☐ NO ☐

PLEASE NOTE: PROOF OF LASIK SURGERY MAY BE REQUIRED FOR SUNGLASS BENEFIT

IS THIS A PRESCRIPTION CHANGE FROM LAST YEAR? YES ☐ NO ☐

BEST CORRECTED VISUAL ACUITY R.E. 20/ L.E. 20/

RVS/CPT	EXAMINATION FEE	RVS/CPT	OTHER CHARGES
	$		$

DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Base
R.E.	•	•			
L.E.	•	•			

READING ADD R.E. + • L.E. + •

SPECIAL INSTRUCTIONS

SIGNATURE DATE

PLEASE TYPE OR PRINT NAME OF DOCTOR / PARTICIPATING PROVIDER NO.

STREET ADDRESS

CITY, STATE and ZIP CODE

PART 3. TO BE COMPLETED BY DISPENSER
PLEASE USE BLACK INK ONLY!

DATE OF ORDER	DEL. DATE	SNGL VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ PROGRESSIVE ☐ CONTACTS ☐

RIGHT LENS CHARGE	$
LEFT LENS CHARGE	$
OVERSIZE CHARGE, IF ANY	$
☐ PRISM CHARGE ☐ OTHER _____ ☐ SLAB OFF CHARGE _____	$
TINT CHARGE COLOR _____ No. _____	$
FRAME CHARGE NAME OF FRAME _____	$
IS FRAME SIZE LESS THAN:	61MM ☐ 56MM ☐
CONTACT LENS CHARGE ☐ HARD ☐ SOFT	$
PLANO SUNGLASSES (PREFABRICATED OR NON-PRESCRIPTION)	$
TOTAL FOR OPTICAL MATERIALS	$

SPECIAL INSTRUCTIONS

SIGNATURE DATE

PLEASE TYPE OR PRINT NAME OF DISPENSARY / PARTICIPATING PROVIDER NO.

STREET ADDRESS

CITY, STATE and ZIP CODE

EXAMINATION ELIGIBILITY VERIFICATION NO. _____

MATERIALS ELIGIBILITY VERIFICATION NO. _____

For your protection, State law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(01/09) REV