MES Vision

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

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

PLEASE USE BLACK INK ONLY

INSURED / PATIENT PORTION

PATIENT'S NAME (Last Name, First)	GENDER ☐ MALE ☐ FEMALE	EMPLOYEE'S IDENTIFICATION NO.
EMPLOYEE'S NAME	RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ DOMESTIC PARTNER ☐ DOMICILE ADULT ☐ DISABLED	PATIENT'S BIRTHDATE MONTH DAY YEAR
ADDRESS	NAME OF EMPLOYER	GROUP POLICY NUMBER
CITY, STATE, and ZIP CODE	WAS CARE REQUIRED BECAUSE OF AN INJURY OR ILLNESS? ☐ NO ☐ YES	IF "YES," PLEASE EXPLAIN:
E-MAIL	IS PATIENT FULL TIME STUDENT? ☐ NO ☐ YES	SCHOOL NAME:
OTHER VISION COVERAGE? IF "YES," GIVE NAME OF CARRIER AND POLICY NUMBER ☐ YES ☐ NO	POLICY NUMBER:	NAME OF CARRIER:

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 _____

EXAMINER / DISPENSER PORTION

VERIFICATION #:

CHECK CONDITIONS PATIENT IS KNOWN TO HAVE
☐ DIABETES ☐ HIGH CHOLESTEROL ☐ HYPERTENSION ☐ GLAUCOMA

OTHER CONDITIONS/ DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD 9 / 10 Codes)

Diagnosis : _____ - _____ Diagnosis : _____ - _____

Diagnosis : _____ - _____ Diagnosis : _____ - _____

DIALATION : ☐ YES ☐ NO RETINAL PHOTOS : ☐ YES ☐ NO

PRESCRIBED
☐ **Single Vision** ☐ **Bifocal** ☐ **Trifocal** ☐ **Progressive** ☐ **Contacts**

Rx	Sphere	Cylinder	Axis	Prism	Base Curve
R.E.					
L.E.					

READING ADD R.E. + L.E. +

EXAM DATE: CL FITTING DATE:

HCPC/CPT CODES	CHARGES
	$
	$
	$
	$
TOTAL EXAM CHARGES	$ 0

VERIFICATION #:

DATE OF ORDER: DELIVERY DATE:

HCPC/CPT CODES	EYEWEAR	CHARGE
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
CONTACTS	BRAND	$
FRAME IS FRAME SIZE LESS THAN	FRAME NUMBER ☐ 56 ☐ 61	$
PLANO SUNGLASSES (PRE FABRICATED / NON-RX)	PROOF OF LASIK SURGERY MAY BE REQUIRED FOR SUNGLASS BENEFIT	$
COB: List the total overage on this line COB itemized charges above must be patient out of pocket		$
TOTAL FOR OPTICAL MATERIALS		$ 0

NAME OF DOCTOR	PARTICIPATING PROVIDER NO.	NAME OF DISPENSARY	PARTICIPATING PROVIDER NO.
EMAIL ADDRESS	NPI NO.	EMAIL ADDRESS	NPI NO.
ADDRESS		ADDRESS	
CITY, STATE and ZIP CODE		CITY, STATE and ZIP CODE	
SIGNATURE	DATE	SIGNATURE	DATE

Rev 2012

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.