

**Medical Eye Services, Inc.**  
**INDEPENDENT MEDICAL REVIEW (IMR)**  
**Application Form**

Patient's Name _____	Date of Birth _____
Subscriber's Name _____	ID # _____
Patient's Address _____	Telephone # _____
City _____ State _____	Zip _____ Email Address _____

Patient's Condition (circle all that apply): \_\_\_\_\_ Keratoconus/Anisometropia/Aphakia/Astigmatism/Myopia/Hyperopia

Contact Lens Charge \$ \_\_\_\_\_ Contact Lens Fitting Charge \$ \_\_\_\_\_

Service/Benefit Requested \_\_\_\_\_

Date of Service \_\_\_\_\_ Appeal Denial Date \_\_\_\_\_

Provider Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Provider Address \_\_\_\_\_

**Prior to submitting this Application Form, the Enrollee must participate in Medical Eye Services' (MES) Appeals Process and submit all relevant documents to MES for evaluation.**

By submitting this Application Form, as the Enrollee, you have the right to provide information or documentation, either directly or through your provider, regarding the following:

- (a) A provider recommendation indicating that the disputed health care service is medically necessary for the Enrollee's medical condition.
- (b) Medical information or justification that a disputed health care service was medically necessary for the Enrollee's medical condition.
- (c) Reasonable information supporting the Enrollee's position, including all information provided to the Enrollee by MES or any of its Participating Providers, still in the possession of the Enrollee, a copy of any materials the Enrollee submitted to MES in support of the grievance, as well as any additional material that the Enrollee believes is relevant.

Upon receipt of the Independent Medical Review Application Form the Enrollee will receive further correspondence from the Department of Managed Health Care (DMHC). A decision not to participate in the independent medical review process may cause the forfeiture of any statutory right to pursue legal action against MES regarding the disputed health care service.

**Consent Statement to Release Records**

*I consent to the release of any necessary medical records from MES, from any of its Participating Providers, and any out-of-plan providers, in which I may have consulted on this matter.*

\_\_\_\_\_ Date \_\_\_\_\_ Enrollee Signature \_\_\_\_\_

Please send this completed Application Form to the DMHC and a copy of all materials to MES to the addresses provided below. Please submit copies since originals cannot be returned.

Department of Managed Health Care (DMHC) Attn: HMO Help Center, IMR Unit 980 Ninth Street, Suite 500 Sacramento, CA 95814 <i>Or by facsimile – (916) 229-4328</i>	&	Medical Eye Services, Inc. (MES) Attn: Benefit Resolutions Department P.O. Box 25209 Santa Ana, CA 92799 <i>Or by facsimile – (714) 619-4662</i>
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