

Please forward claims to:

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 MES 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
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 <input type="checkbox"/> NO <input type="checkbox"/>		WAS CARE REQUIRED BECAUSE OF AN INJURY OR ILLNESS? IF "YES," PLEASE EXPLAIN: YES <input type="checkbox"/> NO <input type="checkbox"/>	
IF DEPENDENT AGE OVER CONTRACT AGE LIMIT, ARE THEY A FULL-TIME STUDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		STUDENT'S SOCIAL SEC. NO.	NAME OF SCHOOL:

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 <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> PROGRESSIVE <input type="checkbox"/> CONTACTS <input type="checkbox"/>	
HAS CATARACT SURGERY BEEN PERFORMED YES <input type="checkbox"/> NO <input type="checkbox"/> DATE: _____	
IS THIS A PRESCRIPTION CHANGE FROM LAST YEAR? YES <input type="checkbox"/> NO <input type="checkbox"/>	BEST CORRECTED VISUAL ACUITY R.E. 20/ L.E. 20/
RVS/CPT	EXAMINATION FEE
RVS/CPT	OTHER CHARGES

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

DATE OF ORDER	DEL. DATE	SNGL VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> PROGRESSIVE <input type="checkbox"/> CONTACTS <input type="checkbox"/>
RIGHT LENS CHARGE	\$	
LEFT LENS CHARGE	\$	
OVERSIZE CHARGE, IF ANY	\$	
IS THIS A PRESCRIPTION CHANGE FROM LAST YEAR? YES <input type="checkbox"/> NO <input type="checkbox"/>	PRISM CHARGE <input type="checkbox"/> OTHER _____ \$ SLAB OFF CHARGE _____ \$	
TINT CHARGE	\$	
COLOR _____ No. _____	\$	
FRAME CHARGE	\$	
NAME OF FRAME _____	\$	
IS FRAME SIZE LESS THAN:	61MM <input type="checkbox"/> 56MM <input type="checkbox"/>	
CONTACT LENS CHARGE	\$	
<input type="checkbox"/> HARD <input type="checkbox"/> SOFT	\$	
READING ADD	R.E. + . L.E. + .	TOTAL FOR OPTICAL MATERIALS

SPECIAL INSTRUCTIONS
Participating Providers Must Call MES for Eligibility Verification at 800/877-6372 or 714/619-4660

COMMENTS
Participating Providers Must Call MES for Eligibility Verification at 800/877-6372 or 714/619-4660

SIGNATURE	DATE
PLEASE TYPE OR PRINT NAME OF DOCTOR	PARTICIPATING PROVIDER NO.
STREET ADDRESS	
CITY, STATE and ZIP CODE	

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.