mesvision

Patient Name:
Provider Name:
Date of Service:
Service Type:

P.O. Box 25209; Santa Ana, CA 92799-5209
(714) 619-4660 ■ (800) 877-6372
Fax: (714) 619-4662 ■ www.mesvision.com

Si usted prefiere este cuestionario en español, por favor llámenos o visite nuestro sitio web.

Medical Eye Services (**MES*Vision***) is the administrator for your company's vision plan. One of our corporate goals is to improve the delivery, claims processing, and servicing of your vision plan whenever possible. We would greatly appreciate your feedback and have enclosed a pre-addressed envelope for your convenience. Thank you.

Please rate the following:	**EXCELLENT**	**GOOD**	**FAIR**	**POOR**	**N/A**
1. Your experience with the examining provider	☐	☐	☐	☐	☐
2. Your experience with the eyewear provider	☐	☐	☐	☐	☐
3. Quality of examination	☐	☐	☐	☐	☐
4. Quality of eyewear	☐	☐	☐	☐	☐
5. Provider staff's understanding of your vision plan	☐	☐	☐	☐	☐

6. Did you feel the need to contact the MESVision Customer Service Department before or after using your vision benefits? **Yes** ☐ **No** ☐
   a) If yes, please rate the experience and provide comments on the back. ☐ ☐ ☐ ☐ ☐
7. Did you feel the need to visit the MESVision website before or after using your vision benefits? **Yes** ☐ **No** ☐
   a) If yes, please rate your experience and provide comments on the back. ☐ ☐ ☐ ☐ ☐
8. Please rate your overall experience ☐ ☐ ☐ ☐ ☐
9. Did you receive benefit material? **Yes** ☐ **No** ☐
   a) If yes, was the information in your benefit material helpful? **Yes** ☐ **No** ☐
   Please provide suggested additions or changes to benefit material in space provided at the back of this page.
10. Did you find a participating provider in your area? **Yes** ☐ **No** ☐
    If "No", please complete and return the form enclosed.

11. When making your appointment, were you able to receive the appointment time within:
    ☐ **1)** less than 1 week ☐ **2)** 1-2 weeks ☐ **3)** 3-4 weeks ☐ **4)** more than 4 weeks ☐ **5)** N/A

12. **a)** After your scheduled appointment, how long did you wait before vision care services began?
    ☐ **1)** less than 10 minutes ☐ **2)** 10-20 minutes ☐ **3)** 21-30 minutes ☐ **4)** more than 30 minutes ☐ **5)** N/A
    b) If it was necessary, was your appointment re-scheduled timely?
    ☐ **1)** less than 1 week ☐ **2)** 1-2 weeks ☐ **3)** 3-4 weeks ☐ **4)** more than 4 weeks ☐ **5)** N/A
    c) If you called your eye doctor after hours, did you get a message advising you how to obtain urgent or emergency care or to contact your medical provider/plan? **Yes** ☐ **No** ☐ **N/A** ☐

13. While at the provider's office:
    a) Were you interested in (and did you ask for) patient educational materials? **Yes** ☐ **No** ☐ If No, go to #14
    (vision care brochures, pamphlets, etc.)?
    b) If interested, did you ask for and receive patient educational materials? **Yes** ☐ **No** ☐
    c) If patient educational materials were not available, what vision care topics were you looking for?
    _____

14. Please specify your language preferences to help us improve our language assistance program.
    Preferred spoken language: _____
    Preferred written language: _____

15. If your preferred spoken language is *not* English, were you able to easily communicate with the provider/provider staff during your office appointment? **Yes** ☐ **No** ☐
    If No, please explain on back of this page.

16. May MES share your survey responses/comments with your provider? **Yes** ☐ **No** ☐
    This is used for quality improvement purposes.