**The Participating Provider Must obtain an Eligibility Verification Number**

mesvision
**PO Box 25209 • Santa Ana, CA 92799-5209**
**(714) 619-4660 (800) 877-6372 TTY/TDD (877) 735-2929**
**https://www.mesvision.com/providers/login**

**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 ☐ DOMICILED 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

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: MONTH DAY YEAR / /

CL FITTING DATE: MONTH DAY YEAR / /

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

Diagnosis : _____ . _____ Diagnosis : _____ . _____

Diagnosis : _____ . _____ Diagnosis : _____ . _____

| HCPC/CPT CODES | CHARGES |
|---|---|
| | $ |
| | $ |
| | $ |
| | $ |
| **TOTAL EXAM CHARGES** | $ |

NAME OF DOCTOR — PARTICIPATING PROVIDER NO.

EMAIL ADDRESS — NPI NO.

ADDRESS

CITY, STATE and ZIP CODE

SIGNATURE — DATE

**VERIFICATION #:**

DATE OF ORDER: MONTH DAY YEAR / /

DELIVERY DATE: MONTH DAY YEAR / /

| HCPC/CPT CODES | EYEWEAR | CHARGE |
|---|---|---|
| | L ☐ R ☐ | $ |
| | L ☐ R ☐ | $ |
| | L ☐ R ☐ | $ |
| | L ☐ R ☐ | $ |
| | L ☐ R ☐ | $ |
| | L ☐ R ☐ | $ |
| | L ☐ R ☐ | $ |
| 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 | $ |
| CONTACTS (CL) | | $ |
| CL MANUFACTURER | CL BRAND | NO. OF CL BOXES |
| COB: List the total overage on this line<br>COB itemized charges above must be patient out of pocket | | $ |
| **TOTAL FOR OPTICAL MATERIALS** | | $ |

NAME OF DISPENSER — PARTICIPATING PROVIDER NO.

EMAIL ADDRESS — NPI NO.

ADDRESS

CITY, STATE and ZIP CODE

SIGNATURE — DATE

Rev 2018

**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.**