mesvision®
PO Box 25209 • Santa Ana, CA 92799-5209
(714) 619-4660 (888) 859-5841 TTY/TDD (877) 735-2929
https://www.mesvision.com/providers/login

The Participating Provider Must obtain an Eligibility Verification Number

PLEASE USE BLACK INK ONLY

INSURED / PATIENT PORTION

PATIENT'S NAME (Last Name, First)

GENDER ☐ MALE ☐ FEMALE ☐ NON-BINARY

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 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 2019

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.