

Please forward claims to:

# MESVision

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 MESVision 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 PLEASE 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 HEALTHWAY OF SAN DIEGO COUNTY TRUST		GROUP POLICY NUMBER VCP9524286	
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? YES <input type="checkbox"/> NO <input type="checkbox"/>		IF "YES," PLEASE EXPLAIN:	
IF DEPENDENT AGE OVER CONTRACT AGE LIMIT, ARE THEY A FULL-TIME STUDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		STUDENT'S ID NUMBER	NAME OF SCHOOL:		
CHECK CONDITION(S) PATIENT IS KNOWN TO HAVE:      DIABETES <input type="checkbox"/> DIABETIC RETIN <input type="checkbox"/> HYPERTENSION <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> ARMD <input type="checkbox"/> ARCUS <input type="checkbox"/> NONE <input type="checkbox"/>					
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!			PART 3. TO BE COMPLETED BY DISPENSER PLEASE USE BLACK INK ONLY!		
DATE OF EXAMINATION		REFRACTION	DATE OF ORDER	DEL. DATE	SINGL VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/>
		NO REFRACTION			PROGRESSIVE <input type="checkbox"/> CONTACTS <input type="checkbox"/>
IF YOU PRESCRIBED GLASSES, CHECK ALL THAT APPLY SINGL VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> PROGRESSIVE <input type="checkbox"/> CONTACTS <input type="checkbox"/>			RIGHT LENS CHARGE		\$
HAS CATARACT SURGERY BEEN PERFORMED YES <input type="checkbox"/> NO <input type="checkbox"/> DATE: _____			LEFT LENS CHARGE		\$
HAS LASIK SURGERY BEEN PERFORMED YES <input type="checkbox"/> NO <input type="checkbox"/>			OVERSIZE CHARGE, IF ANY		\$
PLEASE NOTE: PROOF OF LASIK SURGERY MAY BE REQUIRED FOR SUNGLASS BENEFIT			<input type="checkbox"/> PRISM CHARGE <input type="checkbox"/> OTHER _____		\$
IS THIS A PRESCRIPTION CHANGE FROM LAST YEAR? YES <input type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> SLAB OFF CHARGE _____		\$
BEST CORRECTED VISUAL ACUITY R.E. 20/      L.E. 20/		RVS/CPT	OTHER CHARGES	TINT CHARGE	
EXAMINATION FEE		\$	\$	COLOR _____ No. _____	
DOCTOR'S PRESCRIPTION			FRAME CHARGE		\$
			NAME OF FRAME _____		
Sphere      Cylinder      Axis      Prism      Base			IS FRAME SIZE LESS THAN:		61MM <input type="checkbox"/> 56MM <input type="checkbox"/>
R.E.      .      .      .      .      .			CONTACT LENS CHARGE		\$
L.E.      .      .      .      .      .			<input type="checkbox"/> HARD <input type="checkbox"/> SOFT		
READING ADD      R.E.      +      .      L.E.      +      .			PLANO SUNGLASSES (PREFABRICATED OR NON-PRESCRIPTION)		\$
SPECIAL INSTRUCTIONS			TOTAL FOR OPTICAL MATERIALS		\$
SPECIAL INSTRUCTIONS			SPECIAL INSTRUCTIONS		
SIGNATURE _____ DATE _____			SIGNATURE _____ DATE _____		
PLEASE TYPE OR PRINT NAME OF DOCTOR		PARTICIPATING PROVIDER NO.	PLEASE TYPE OR PRINT NAME OF DISPENSARY		PARTICIPATING PROVIDER NO.
STREET ADDRESS			STREET ADDRESS		
CITY, STATE and ZIP CODE			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.