MESVision®

PO Box 25209 • Santa Ana, CA 92799-5209
(714) 619-4660 (800) 877-6372 TTY/TDD (877) 735-2929
MESVision.com

The Participating Provider Must Call MESVision to obtain an Eligibility Verification Number

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 ☐ DOMICILE 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

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

Diagnosis : _____ - _____ Diagnosis : _____ - _____

Diagnosis : _____ - _____ Diagnosis : _____ - _____

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:

CL FITTING DATE:

HCPC/CPT CODES	CHARGES
	$
	$
	$
	$
TOTAL EXAM CHARGES	$ 0

NAME OF DOCTOR

PARTICIPATING PROVIDER NO.

EMAIL ADDRESS

NPI NO.

ADDRESS

CITY, STATE and ZIP CODE

SIGNATURE DATE

VERIFICATION #:

DATE OF ORDER:

DELIVERY DATE:

HCPC/CPT CODES	EYEWEAR	CHARGE
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
CONTACTS	BRAND	$
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	$
COB: List the total overage on this line COB itemized charges above must be patient out of pocket		$
TOTAL FOR OPTICAL MATERIALS		$ 0

NAME OF DISPENSARY

PARTICIPATING PROVIDER NO.

EMAIL ADDRESS

NPI NO.

ADDRESS

CITY, STATE and ZIP CODE

SIGNATURE DATE

Rev 2012

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.