

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	GROUP POLICY NUMBER
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?                      IF "YES," PLEASE EXPLAIN: YES <input type="checkbox"/> NO <input type="checkbox"/>	
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	
		NO REFRACTION				SINGL VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> 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"/>		BEST CORRECTED VISUAL ACUITY		TINT CHARGE		\$	
RVS/CPT                      EXAMINATION FEE		RVS/CPT                      OTHER CHARGES		COLOR _____ No. _____		\$	
\$		\$		FRAME CHARGE		\$	
DOCTOR'S PRESCRIPTION				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.	.	.				\$	
READING ADD		R.E. + .	L.E. + .	<input type="checkbox"/> HARD <input type="checkbox"/> SOFT			
				PLANO SUNGLASSES (PREFABRICATED OR NON-PRESCRIPTION)			
				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.