

Please forward claims to:

Medical Eye Services

PO Box 93033 • Long Beach, CA 90809

(800) 877-6372 (562) 425-9528

www.mesvision.com

The Participating Provider Must Call MES 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											
PATIENT'S NAME (Last Name, First)				SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		EMPLOYEE'S SOCIAL SECURITY # OR MEMBER ID #					
EMPLOYEE'S NAME				RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> 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? 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 SOCIAL SEC. NO.		NAME OF SCHOOL:					
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					PART 3. TO BE COMPLETED BY DISPENSER						
DATE OF EXAMINATION		REFRACTION		DATE OF ORDER		DEL. DATE		SNGL 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 SNGL VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> PROGRESSIVE <input type="checkbox"/> CONTACT <input type="checkbox"/>					RIGHT LENS CHARGE		\$				
HAS CATARACT SURGERY BEEN PERFORMED YES <input type="checkbox"/> NO <input type="checkbox"/> DATE: _____					LEFT LENS CHARGE		\$				
CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? YES <input type="checkbox"/> NO <input type="checkbox"/>					OVERSIZE CHARGE, IF ANY		\$				
IS THIS A PRESCRIPTION CHANGE FROM LAST YEAR? YES <input type="checkbox"/> NO <input type="checkbox"/>		BEST CORRECTED VISUAL ACUITY R.E. 20/ _____ L.E. 20/ _____		<input type="checkbox"/> PRISM CHARGE <input type="checkbox"/> OTHER _____				\$			
RVS/CPT		EXAMINATION FEE		RVS/CPT		OTHER CHARGES		TINT CHARGE			
		\$				\$		COLOR _____ No. _____			
DOCTOR'S PRESCRIPTION					FRAME CHARGE		\$				
					Sphere		Cylinder		Axis		Prism
R.E.		.		.						IS FRAME SIZE LESS THAN: 61MM <input type="checkbox"/> 56MM <input type="checkbox"/>	
L.E.		.		.						CONTACT LENS CHARGE <input type="checkbox"/> HARD <input type="checkbox"/> SOFT	
READING ADD		R.E.		L.E.						TOTAL FOR OPTICAL MATERIALS	
		+		.						\$	
SPECIAL INSTRUCTIONS Participating Provider Must Call MES for Eligibility Verification at 800/877-6372 or 562/425-9528					COMMENTS Participating Provider Must Call MES for Eligibility Verification at 800/877-6372 or 562/425-9528						
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, California 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.