

CLAIMS SUBMITTED FOR: EXAM ONLY  MATERIALS ONLY  EXAM & MATERIALS   
(PLEASE CHECK ONLY ONE BOX)

PLEASE FORWARD CLAIMS TO:  
MESVISION  
P.O. BOX 25208, SANTA ANA, CA 92799-5208  
(877) 601-9083 (714) 619-4660

**VISION CLAIM FORM**

**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 a state prison.**

NOTE: Please complete the entire enrollment form. This form cannot be processed if information is incomplete.

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

**SECTION 1 – EMPLOYEE/PATIENT TO COMPLETE AND SIGN THIS SECTION**

PATIENT'S NAME (LAST NAME FIRST)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	EMPLOYEE SOCIAL SECURITY NUMBER
EMPLOYEE'S NAME	RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE/DOM.PRTNR. <input type="checkbox"/> CHILD	PATIENT'S BIRTHDATE MONTH DAY YEAR
STREET ADDRESS	NAME OF EMPLOYER	GROUP NO.
CITY, STATE, AND ZIP CODE		
OTHER VISION COVERAGE? IF "YES," GIVE NAME OF CARRIER AND POLICY NUMBER <input type="checkbox"/> YES <input type="checkbox"/> NO		
WAS CARE REQUIRED BECAUSE OF AN INJURY OR ILLNESS? IF "YES," PLEASE EXPLAIN <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF DEPENDENT AGE OVER CONTRACT AGE LIMIT, ARE THEY A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
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.		
PATIENT SIGNATURE _____		DATE _____

**SECTION 2 – TO BE COMPLETED BY DOCTOR**

DATE OF EXAMINATION	REFRACTION	
	NO REFRACTION	
IF YOU PRESCRIBED GLASSES, CHECK THE TYPE <input type="checkbox"/> SINGLE VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> PROGRESSIVE <input type="checkbox"/> CONTACT LENS		
HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE: _____		
CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IS THIS A PRESCRIPTION BEST CORRECTED VISUAL ACUITY		
CHANGE FROM LAST YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO	R.E. 20/	L.E. 20/
RVS/CPT	EXAMINATION FEE	
	\$ _____	
<b>DOCTOR'S PRESCRIPTION</b>		
	Sphere	Cylinder
	Axis	Prism
	Base	
R.E.	•	•
L.E.	•	•
READING ADD	R.E. + •	L.E. + •
SPECIAL INSTRUCTIONS: In order to use this form: The Participating Provider must call MESVision for eligibility Verification at (877) 601-9083		
SIGNATURE		DATE
PLEASE TYPE OR PRINT NAME OF DOCTOR		ECN PROVIDER NO.
STREET ADDRESS		
CITY, STATE, AND ZIP CODE		

**SECTION 3 – TO BE COMPLETED BY DISPENSER**

DATE OF ORDER	DATE OF DELIVERY	<input type="checkbox"/> SINGLE VISION	<input type="checkbox"/> TRIFOCAL
		<input type="checkbox"/> BIFOCAL	<input type="checkbox"/> PROG
RIGHT LENS CHARGE		\$	
LEFT LENS CHARGE		\$	
OVERSIZE CHARGE, IF ANY		\$	
<input type="checkbox"/> PRISM CHARGE <input type="checkbox"/> OTHER		\$	
<input type="checkbox"/> SLAB OFF CHARGE _____		\$	
TINT CHARGE		\$	
COLOR _____ NO. _____		\$	
FRAME CHARGE		\$	
NAME OF FRAME _____		\$	
ENTER FRAME SIZE		MM	
CONTACT LENS CHARGE		\$	
<input type="checkbox"/> HARD <input type="checkbox"/> SOFT		\$	
TOTAL FOR OPTICAL MATERIALS		\$	
COMMENTS			
SIGNATURE		DATE	
PLEASE TYPE OR PRINT NAME OF DISPENSARY		ECN PROVIDER NO.	
STREET ADDRESS			
CITY, STATE, AND ZIP CODE			