

Please forward claims to:

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 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
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 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
PLEASE USE BLACK INK ONLY!

PART 3. TO BE COMPLETED BY DISPENSER
PLEASE USE BLACK INK ONLY!

DATE OF EXAMINATION	REFRACTION NO REFRACTION	DATE OF ORDER	DEL. DATE	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	\$	
IS THIS A PRESCRIPTION CHANGE FROM LAST YEAR? YES <input type="checkbox"/> NO <input type="checkbox"/>		OVERSIZE CHARGE, IF ANY	\$	
BEST CORRECTED VISUAL ACUITY R.E. 20/ L.E. 20/		<input type="checkbox"/> PRISM CHARGE <input type="checkbox"/> OTHER _____	\$	
RVS/CPT	EXAMINATION FEE	<input type="checkbox"/> SLAB OFF CHARGE _____	\$	
RVS/CPT	OTHER CHARGES	TINT CHARGE	\$	
DOCTOR'S PRESCRIPTION		COLOR _____ No. _____	\$	
Sphere	Cylinder	Axis	Prism	Base
R.E.	.	.		
L.E.	.	.		
READING ADD	R.E.	L.E.		
	+	.	+	.
SPECIAL INSTRUCTIONS		FRAME CHARGE	\$	
Participating Providers Must Call MES for Eligibility Verification at 800/877-6372 or 714/619-4660		NAME OF FRAME _____	\$	
SIGNATURE		DATE	IS FRAME SIZE LESS THAN: 61MM <input type="checkbox"/> 56MM <input type="checkbox"/>	
PLEASE TYPE OR PRINT NAME OF DOCTOR		PARTICIPATING PROVIDER NO.	CONTACT LENS CHARGE	
STREET ADDRESS		\$		
CITY, STATE and ZIP CODE		<input type="checkbox"/> HARD <input type="checkbox"/> SOFT		
EXAMINATION ELIGIBILITY VERIFICATION NO. _____		TOTAL FOR OPTICAL MATERIALS		
MATERIALS ELIGIBILITY VERIFICATION NO. _____		\$		

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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.