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 ☐ NO ☐	WAS CARE REQUIRED BECAUSE OF AN INJURY OR ILLNESS? YES ☐ NO ☐	IF "YES," PLEASE EXPLAIN:
IF DEPENDENT AGE OVER CONTRACT AGE LIMIT, ARE THEY A FULL-TIME STUDENT? YES ☐ NO ☐	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!

DATE OF EXAMINATION	REFRACTION	
	NO REFRACTION	

IF YOU PRESCRIBED GLASSES, **CHECK ALL THAT APPLY**
SNGL VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ PROGRESSIVE ☐ CONTACTS ☐

HAS CATARACT SURGERY BEEN PERFORMED YES ☐ NO ☐ DATE:

IS THIS A PRESCRIPTION CHANGE FROM LAST YEAR? YES ☐ NO ☐

BEST CORRECTED VISUAL ACUITY R.E. 20/ L.E. 20/

RVS/CPT	EXAMINATION FEE	RVS/CPT	OTHER CHARGES
	$		$

DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Base
R.E.	•	•			
L.E.	•	•			

READING ADD R.E. + • L.E. + •

SPECIAL INSTRUCTIONS

Participating Providers Must Call MES for Eligibility Verification at 800/877-6372 or 714/619-4660

SIGNATURE DATE

PLEASE TYPE OR PRINT NAME OF DOCTOR | PARTICIPATING PROVIDER NO.

STREET ADDRESS

CITY, STATE and ZIP CODE

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

DATE OF ORDER	DEL. DATE	SNGL VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ PROGRESSIVE ☐ CONTACTS ☐
RIGHT LENS CHARGE		$
LEFT LENS CHARGE		$
OVERSIZE CHARGE, IF ANY		$
☐ PRISM CHARGE ☐ OTHER _____ ☐ SLAB OFF CHARGE _____		$
TINT CHARGE COLOR _____ No. _____		$
FRAME CHARGE NAME OF FRAME _____		$
IS FRAME SIZE LESS THAN:		61MM ☐ 56MM ☐
CONTACT LENS CHARGE ☐ HARD ☐ SOFT		$
TOTAL FOR OPTICAL MATERIALS		$

COMMENTS

Participating Providers Must Call MES for Eligibility Verification at 800/877-6372 or 714/619-4660

SIGNATURE DATE

PLEASE TYPE OR PRINT NAME OF DISPENSARY | PARTICIPATING PROVIDER NO.

STREET ADDRESS

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.

(04/04) REV