



PATIENT NAME		RELATIONSHIP TO EMPLOYEE				PATIENT BIRTHRATE			EMPLOYEE'S SOC. SEC. NO.		
		SELF	SPOUSE	CHILD	OTHER	MO	DAY	YEAR			
DOES PATIENT HAVE OTHER VISION COVERAGE? YES NO		FULL TIME STUDENT IF OVER AGE 19						EMPLOYEE NAME (Last Name, First Name, Middle Initial)			
		SCHOOL CITY						ADDRESS (No. & Street)			
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					IS THIS CLAIM			PRIMARY SECONDARY			
								CITY STATE			
OTHER INSURED'S POLICY OR GROUP NUMBER					IS PATIENT'S CONDITION RELATED TO:			ZIP CODE TELEPHONE (INCLUDE AREA CODE)			
OTHER INSURED'S DATE OF BIRTH			SEX		EMPLOYMENT? (CURRENT OR PREVIOUS)			DATE OF BIRTH		SEX	
MM DD YY			M F		YES NO			MM DD YY		M F	
EMPLOYER'S NAME OR SCHOOL NAME					AUTO ACCIDENT? PLACE (State)			EMPLOYER'S NAME			
					YES NO			CITY OF SAGINAW			
INSURANCE PLAN NAME OR PROGRAM NAME					OTHER ACCIDENT?						
					YES NO						

PATIENT/EMPLOYEE INFORMATION

DESCRIPTION						DATE			CHARGES		CO-PAYMENT PATIENT PAID		
EXAMINATION						MM	DD	YY					
CONTACT LENS EXAMINATION													
GLAUCOMA TREATMENT													
Could visual acuity be corrected to 20/70 in the better eye by use of conventional lenses? Yes No						PAY: DOCTOR PATIENT							
Have glasses/contact lenses been prescribed? Yes No						SPHERE		CYLINDER		AXIS		PRISM BASE	
DIAGNOSIS:						R							
						L							
						ADD		SEG. HGT.		SEG. WIDTH		Dist. P.D. Near	
						R							
						L							

EXAMINATION

DESCRIPTION				DATE OF SERVICE			CHARGES		DISCOUNT		CO-PAYMENT PATIENT PAID	
LENSES NAME OF MFG. LABORATORY				MM	DD	YY						
Single vision												
Bifocal												
Trifocal												
Progressive												
Lenticular												
FRAMES NAME MFG.												
CONTACT LENSES Cosmetic												
20/70 Correction												
EXTRAS Itemize all additional charges:												
1. Tint Type												
2. Oversize (Over 65 mm)												
3. Other												
4. Other												

MATERIALS

PAY: DOCTOR PATIENT				TOTALS							
PROVIDER NAME				I hereby certify that the foregoing services/materials have been completed/delivered. The charges submitted are actual charges and intended to be collected. I understand any false claim, statements, or documents may be prosecuted under applicable Federal or State laws. PROVIDER'S SIGNATURE X							
ADDRESS AND ZIP											
AREA CODE & TEL. NO.											
FEDERAL TAX I.D. NUMBER:											

PROVIDER

TO BE COMPLETED BY PATIENT

I certify that the above information is true and correct and that the services listed above have been completed/delivered. I authorize the release of any information requested, with respect to this claim, to Mutual Eye Claim Audits, Inc., and for the payment of allowable benefits to the provider to the extent not paid by the patient.

X _____ DATE _____

Signature of Eligible Employees or Eligible Dependent

PATIENT