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	Central Unified School Dist	93-007
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