

Please forward claims to:

# Medical Eye Services

PO Box 25209 • Santa Ana, CA 92799-5209

(800) 877-6372 (714) 619-4660

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)<br>MALE                      FEMALE   | EMPLOYEE'S SOCIAL SECURITY NO.  |
| EMPLOYEE'S NAME   | RELATIONSHIP TO EMPLOYEE<br>SELF                      SPOUSE                      CHILD |   | PATIENT'S BIRTHDATE<br>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<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | WAS CARE REQUIRED BECAUSE OF AN INJURY OR ILLNESS?                      IF "YES," PLEASE EXPLAIN:<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| IF DEPENDENT AGE OVER CONTRACT AGE LIMIT, ARE THEY A FULL-TIME STUDENT?<br>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**  
**USE BLACK INK ONLY!**

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

|  |  |  |           |   |
|--|--|--|-----------|---|
| DATE OF EXAMINATION  | REFRACTION   | DATE OF ORDER  | DEL. DATE | SNGL VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> |
|  | NO REFRACTION  |  |           | PROGRESSIVE <input type="checkbox"/> CONTACTS <input type="checkbox"/>                                  |
| IF YOU PRESCRIBED GLASSES, CHECK ALL THAT APPLY<br>SNGL VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> PROGRESSIVE <input type="checkbox"/> CONTACT <input type="checkbox"/> |  | RIGHT LENS CHARGE  | \$        |   |
| HAS CATARACT SURGERY BEEN PERFORMED<br>YES <input type="checkbox"/> NO <input type="checkbox"/> DATE: _____  |  | LEFT LENS CHARGE   | \$        |   |
| CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | OVERSIZE CHARGE, IF ANY  | \$        |   |
| IS THIS A PRESCRIPTION CHANGE FROM LAST YEAR?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | BEST CORRECTED VISUAL ACUITY<br>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                                   | \$        |   |
| \$   |  | TINT CHARGE  | \$        |   |
|  |  | COLOR _____ No. _____  |           |   |
| <b>DOCTOR'S PRESCRIPTION</b>   |  |  |           |   |
|  | Sphere   | Cylinder   | Axis      | Prism   |
|  |  |  |           | Base  |
| R.E.   | •  | •  |           |   |
| L.E.   | •  | •  |           |   |
| READING ADD  | R.E.   | L.E.   |           |   |
|  | +    •   | +    •   |           |   |
| SPECIAL INSTRUCTIONS   |  |  | COMMENTS  |   |

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

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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.**