Vision Claim Form Administered by Medical Eye Services (MES)

For your protection, California 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.

Note: Please complete the entire enrollment form. This form cannot be processed if information is incomplete.

Important: Please print all sections in black ink.

**Section 1: Employee/Patient to Complete and Sign This Section**

- **Patient's Name (Last Name First):**
- **Employee's Name:**
- **Street Address:**
- **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? If "Yes," please explain:
- **Yes** ☐  **No** ☐

If dependent age over contract age limit, are they a full-time student?
- **Yes** ☐  **No** ☐

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.

**Patient Signature:**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

**Section 2: To Be Completed by Doctor**

- **Date of Examination:**
- Refraction:
  - **No Refraction:**
- If you prescribed glasses, check the type:
  - Single Vision ☐  Bi-focal ☐  Tri-focal ☐  Progressive ☐  Contact Lens ☐
- Has cataract surgery been performed?
  - **Yes** ☐  **No** ☐
- Can visual acuity be restored to at least 20/20 in the better eye with conventional glasses?
  - **Yes** ☐  **No** ☐

**Prescription Information**

<table>
<thead>
<tr>
<th>Sphere</th>
<th>Cylinder</th>
<th>Axis</th>
<th>Prism</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>R.E.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L.E.</td>
<td></td>
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</tr>
</tbody>
</table>

Reading Add: R.E. ☐  L.E. ☐

Specify strength and spherical equivalent:

**SPECIAL INSTRUCTIONS:** In order to use this form, the participating provider must call MES for eligibility verification at (800) 877-6372.

**Signature:**

<table>
<thead>
<tr>
<th>Please type or print name of doctor:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ECN Provider No.:</strong></td>
</tr>
</tbody>
</table>

**Street Address:**

**City, State, and Zip Code:**

**C-4669-01 (11/03) Exam Eligibility Verification No.:**

**Materials Eligibility Verification No.:**