Please Forward Claims To:

MEDICAL EYE SERVICES (MES)
P.O. Box 25208, Santa Ana, CA 92799-5208
(877) 601-9083 (714) 619-4660

Blue Shield of California
An Independent Member of the Blue Shield Association

Claims Submitted For: **EXAM ONLY** ☐ **MATERIALS ONLY** ☐ **EXAM & MATERIALS** ☐
(PLEASE CHECK ONLY ONE BOX)

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 a 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)	GENDER ☐ MALE ☐ FEMALE	EMPLOYEE SOCIAL SECURITY NUMBER
EMPLOYEE'S NAME	RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE/DOM.PRTNR. ☐ CHILD	PATIENT'S BIRTHDATE MONTH DAY YEAR
STREET ADDRESS	NAME OF EMPLOYER	GROUP NO.
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 _____ DATE _____

SECTION 2 – TO BE COMPLETED BY DOCTOR

DATE OF EXAMINATION	REFRACTION	
	NO REFRACTION	

IF YOU PRESCRIBED GLASSES, CHECK THE TYPE
☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ PROGRESSIVE ☐ CONTACT LENS

HAS CATARACT SURGERY BEEN PERFORMED?
☐ YES ☐ NO DATE:

CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? ☐ YES ☐ NO

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

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

RVS/CPT

EXAMINATION FEE
$

DOCTOR'S PRESCRIPTION

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

READING ADD	R.E.	+ •	L.E.	+ •

SPECIAL INSTRUCTIONS: **In order to use this form: The Participating Provider must call MES for eligibility Verification at (877) 601-9083**

SIGNATURE	DATE
PLEASE TYPE OR PRINT NAME OF DOCTOR	ECN PROVIDER NO.
STREET ADDRESS	
CITY, STATE, AND ZIP CODE	

SECTION 3 – TO BE COMPLETED BY DISPENSER

DATE OF ORDER DATE OF DELIVERY

☐ SINGLE VISION ☐ TRIFOCAL ☐ BIFOCAL ☐ PROG

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 _____	$
ENTER FRAME SIZE	MM
CONTACT LENS CHARGE ☐ HARD ☐ SOFT	$
TOTAL FOR OPTICAL MATERIALS	$

COMMENTS

In order to use this form: the Participating Provider must call MES for eligibility Verification at (877) 601-9083

SIGNATURE	DATE
PLEASE TYPE OR PRINT NAME OF DISPENSARY	ECN PROVIDER NO.
STREET ADDRESS	
CITY, STATE, AND ZIP CODE	

EXAM ELIGIBILITY VERIFICATION NO. _____

MATERIALS ELIGIBILITY VERIFICATION NO. _____