Board of Supervisors of Louisiana State University Agricultural & Mechanical College -LSU First /

University of New Orleans





SR01732 1/1/14

(This form to be maintained by the provider's office)

| Employee ID No.: | SECTION I - PROVIDER/PATIENT SECTION | SECTION II - COVERAGE SECTION | | | | | |
|--|---|--|---------------------|------------|----------------------|----------------|--|
| Employee ID No.: Section Name: So Patient Name: So Provider's Name: So So So So So So So S | Employee Name: | Plan Level: I | Designer | | | | |
| Provider's Name: | Employee ID No.: | | _ | n | | \$0 | |
| Relationship: Employee Spouse Child Provider's Name: Provider's Name: Provider's Name: Provider's Name: SECTION III - SERVICE SECTION A. Examination: Yes No 1a. Was examination comprehensive? Yes No 1b. Was disting performed? Yes No 1c. Was this a new parient? Yes No 1c. Countert Lense: Collection Jernses: Additional dispense will be paid by Davis Vision. Parient Spenses Additional dispense will be paid by Davis Vision. Additional dispense will be paid by Davis Vision. Additional dispense will be paid by Davis Vision. Parient Spenses Additional dispense will be paid by Davis Vision. Parient Spenses Additional dispense will be paid by Davis Vision. Parient Charge Dispenses Permet Section V Options Spenses Yes No 1c. Was this a new parient for spenses of the decided of the dispense will be paid by Davis Vision. Permet Section V Options Spenses Permet Section V Options Spenses Permet Section V Options Spenses Yes Translated Planned Keplacement lenses or 1 Included Spenses Yes Section V Options Spenses | | Frame | | | * - | | |
| Relationship: Employee Spouse Child Provider's Name: | Patient Name: | | | | \$0 | | |
| Provider's No.: Authorization No.: LSF Authorization Date: SECTION III - SERVICE SECTION I.a. Was examination comprehensive? Yes No | Relationship: Employee Spouse Child | | | | | | |
| Frovider's No.: Section No.: LSF Authorization No.: LSF Authorization No.: LSF Authorization Date: Section No.: LSF | Provider's Name: | Plan Description: | | | | | |
| Authorization No.: LSF | Provider's No.: | Eye examination (inc | | | | | |
| SECTION III - SERVICE SECTION A. Examination: Yes No | | | | | | | |
| A. Examination: Yes No 1a. Was examination comprehensive? Yes No 1b. Was dilation performed? Yes No 1c. Was this a new patient? Yes No 1d. Primary Diagnosis code: Secondary Diagnosis code (if any): B. Spectacle lesses provided: (check all that apply) 1. Plan Patient's Primary Diagnosis code: Secondary Diagnosis code (if any): B. Spectacle lesses provided: (check all that apply) 1. Plan Patient's Diagnosis code: Collection Lenses: Secondary Diagnosis code (if any): Provider Supplied: Elective D. Frame Provided: Plan Patient's Provider's Diagnosis code (if any): Secondary Diagnosis code (if any): Secondary Diagnosis code (if any): D. Frame Provided: Plan Patient's Provider's Diagnosis code (if any): Secondary Diagnosis code (if any): Secondary Diagnosis code (if any): D. Frame Provided: Plan Patient's Provider's Diagnosis code (if any): Secondary Diagnosis code (if any): Secondary Diagnosis code (if any): D. Frame Provided: Plan Patient's Provider's Diagnosis code (if any): Secondary Diagnosis code: Secondary Diagnosis code | | | | | | | |
| A Examination: Yes No | SECTION III - SERVICE SECTION | Frame | | | | | |
| a. Was cxamination comprehensive? Yes No 1e. Was this a new patient? Yes No 2e. Single Vision Bifocal Trifocal Patient Secretch Patient Secretch Patient Secretch Patient Secretch Patient No No No No No No No N | A. Examination: Yes No No | \$130 plus 20% | | | | | |
| 1c. Was this a new patient? Yes | 1a. Was examination comprehensive? Yes ☐ No ☐ | | | | | | |
| Rate Patient charges for selected options Secondary Diagnosis code (if any): Additional dispense will be paid by Davis Vision. | 1 | | | | | | |
| Secondary Diagnosis code (if any): | 1 | | | | | | |
| Secondary Department of the provided is (check all that apply) | | | | | | | |
| Permiser | | | 1 | | Patient | Additional | |
| 2. Single Vision | | | | | | 1 | |
| C. Coltact Lenses: A multi-packs plan supplied Disposable lenses or: | 2. Single Vision ☐ Bifocal ☐ Trifocal ☐ | Ultraviolet | | | | | |
| Coating Coatin | | Scratch-Resistant | | | | | |
| 2 multi-packs plan supplied Planned Replacement lenses Provider Supplied: Elective Medically Necessary (prior approval required) Patient's Provider's Blended Sagments Sangle Vision D. Frame Provided: Patient's Provider's Blended Sagments Sangle Vision D. Frame Provided: Patient's Provider's Blended Sagments Sangle Vision D. Frame Provided: Provider's Blended Sagments Sangle Vision D. Frame Provided: Segments Sangle Vision D. Frame Provided: Sagments D. Frame Provided: Sagme | _ | Coating | | | | | |
| Provider Supplied: Elective | · · · · · · · · · · · · · · · · · · · | Single Vision | | | Included | N/A | |
| Lenses S20 S10 | | Multifocal | | | Included | N/A | |
| D. Frame Provided: Plan Patient's Provider's Intermediate Vision Sand S10 SECTION VI - SIGNATURE SECTION A. I certify that all of the services and materials indicated above as received are indicated accurately, and authorize the release of any medical or other information necessary to process this claim. Additionally, I certify that I have been informed of all additional items and costs as outlined in Sections IV and V, and I bear the full responsibility for payment of any change associated with any of the items selected. I understand that Progressive Addition Lenses will be furnished upon my request and if I am unable to adapt to these lenses, standard bifocal lenses will be provided with no additional cost. TN Residents: Please see Instruction 6. Patient Signature Date of Service B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. TN Providers: Please see Instruction 6. Authorized Signature Invoice No. Segments Intermediate Vision Lenses Standard Progressive Addition Multifocals Included \$30 Fermium ARC (anti-reflective coating) Premium ARC (anti-reflective coating) Segments Standard Progressive Addition Multifocals Included \$30 Segments Included \$30 Segments Standard Progressive Addition Multifocals Included \$30 Segments Segments Segments Addition Multifocals Included \$30 Segments Segments Addition Multifocals Included \$30 Segments Segments Addition Multifocals Included \$30 Segments Addition Multifocals Included \$30 Segments Addition Multifocals Included \$30 Segments Segments Addition Multifocals Included \$30 Segments Addition Multifocals Included \$30 Segments Addition Multifocals Included \$40 Segments Addition Multifocals Included \$40 Segments Segments Addition | | Lenses | ic | | \$20 | \$10 | |
| Plan Patient's Provider's Standard Progressive Included S30 SECTION VI - SIGNATURE SECTION A. I certify that all of the services and materials indicated above as received are indicated accurately, and authorize the release of any medical or other information necessary to process this claim. Additionally, I certify that I have been informed of all additional items and costs as outlined in Sections IV and V, and I bear the full responsibility for payment of any charge associated with any of the items selected. I understand that Progressive Addition Lenses will be furnished upon my request and if I am unable to adapt to these lenses, standard bifocal lenses will be provided with no additional cost. TN Residents: Please see Instruction 6. Patient Signature | — — — — — — — — — — — — — — — — — — — | Segments | | | \$20 | \$10 | |
| SECTION VI - SIGNATURE SECTION A. I certify that all of the services and materials indicated above as received are indicated accurately, and authorize the release of any medical or other information necessary to process this chaim. Additionally, I certify that I have been informed of all additional items and costs as outlined in Sections IV and V, and I bear the full responsibility for payment of any charge associated with any of the items selected. I understand that Progressive Addition Lenses will be furnished upon my request and if I am unable to adapt to these lenses, standard bifocal lenses will be provided with no additional cost. TN Residents: Please see Instruction 6. Patient Signature Date of Service B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. TN Providers: Please see instruction 6. **For included Fashion or Designer level frames, an additional S10 dispense will apply.**No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/6.00 or greater. **NSTRUCTIONS: 1. Participating provider must complete Sections I,III, V, and VIB. 2. Employee or legal guardian should complete and sign Section VIA. 3. All services rendered should be recorded on a single form. 4. Authorized Signature Invoice No. **Completed forms must be maintained for a period of not less than seven (7) years. 5. Completed forms must be maintained for a period of not less than seven (7) years. 6. Tennessee state law stipulates that it is a crime to knowingly provide flatlee, incomplete or misleading information to an insurance company for the purpose of defrauding the | | Lenses | | | \$30 | \$10 | |
| A. I certify that all of the services and materials indicated above as received are indicated accurately, and authorize the release of any medical or other information necessary to process this claim. Additionally, I certify that I have been informed of all additional items and costs as outlined in Sections IV and V, and I bear the full responsibility for payment of any charge associated with any of the items selected. I understand that Progressive Addition Lenses will be furnished upon my request and if I am unable to adapt to these lenses, standard bifocal lenses will be provided with no additional cost. TN Residents: Please see Instruction 6. Patient Signature Date of Service B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. TN Providers: Please see instruction 6. Authorized Signature Invoice No. Invoice No. Authorized Signature Authorized Signature Invoice No. Authorized Signature The ddition Multifocals Polycarbonate Lenses* S30 \$30 \$30 \$20 Addition Multifocals Polycarbonate Lenses** (anti-reflective coating) Premium ARC (anti-reflective coating) Polarized Lenses Plastic Photosensitive Lenses Plastic Photosensitive Lenses Plastic Photosensitive Lenses Plastic Photosensitive Lenses INSTRUCTIONS: 1. Participating provider must complete Sections I,III, V, and VIB. 2. Employee or legal guardian should complete and sign Section VIA. 3. All services rendered should be recorded on a single form. 4. Authorized signature to small patients with the standard of the Davis Vision Program. TN Providers: 5. Completed forms must be maintained for a period of not less than seven (7) years. 5. Completed forms must be maintained for a period of not less than seven (7) years. 6. Completed forms must be maintained for a period of not less than seven (7) years. 6. Completed forms must be maintained for a period of not less than seven (7) years. 6. Completed forms must be maintained for a period of not less than | Tian - Tancin S - Tiovido S - | Standard Progre Addition Multif | ssive ocals | | Included | \$30 | |
| A. I certify that all of the services and materials indicated above as received are indicated accurately, and authorize the release of any medical or other information necessary to process this claim. Additionally, I certify that I have been informed of all additional items and costs as outlined in Sections IV and V, and I bear the full responsibility for payment of any charge associated with any of the items selected. I understand that Progressive Addition Lenses will be furnished upon my request and if I am unable to adapt to these lenses, standard bifocal lenses will be provided with no additional cost. TN Residents: Please see Instruction 6. Patient Signature Date of Service B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. TN Providers: Please see instruction 6. Authorized Signature Invoice No. Invoice No. Polycarabonate Canti-reflective coating) Premium ARC (anti-reflective coating) Premium ARC (anti-reflective coating) Polarized Lenses Standard ARC (anti-reflective coating) Polarized Lenses Polarized Lenses Plastic Photosensitive Lenses INSTRUCTIONS: INSTRUCTIONS: INSTRUCTIONS: 1. Participating provider must complete Sections I,III, V, and VIB. 2. Employee or legal guardian should complete and sign Section VIA. 3. All services rendered should be recorded on a single form. 4. Authorized signature Invoice No. Invoice No. Invoice No. Invoice No. Polycarbonate ARC (anti-reflective coating) Premium ARC (anti-reflective coating) Premium ARC (anti-reflective coating) Polarized Lenses Standard ARC (anti-reflective coating) Polarized Lenses Standard ARC (anti-reflective coating) Polarized Lenses Standard ARC (anti-reflective coating) Polarized Lenses Polarized Lenses Plastic Photosensitive Lenses Polarized Lenses Plastic Photosensitive Lens | | | | | Included | \$30 | |
| Canti-reflective coating Canti-reflective coating Canti-reflective coating Canti-reflective coating Premium ARC Canti-reflective coating Canti | SECTION VI - SIGNATURE SECTION | Polycarbonate | | | \$30 | \$20 | |
| accurately, and authorize the release of any medical or other information necessary to process this claim. Additionally, I certify that I have been informed of all additional items and costs as outlined in Sections IV and V, and I bear the full responsibility for payment of any charge associated with any of the items selected. I understand that Progressive Addition Lenses will be furnished upon my request and if I am unable to adapt to these lenses, standard bifocal lenses will be provided with no additional cost. TN Residents: Please see Instruction 6. Patient Signature Date of Service B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. TN Providers: Please see instruction 6. Authorized Signature Authorized Signature Invoice No. Invoice No. Invoice No. Premium ARC (anti-reflective coating) Seo S15 S25 High Index Lenses Plastic Photosensitive Lens | A. I certify that all of the services and materials indicated above as received are indicated | Standard ARC (anti-reflective coating) | | | \$35 | \$ 7 | |
| items and costs as outlined in Sections IV and V, and I bear the full responsibility for payment of any charge associated with any of the items selected. I understand that Progressive Addition Lenses will be furnished upon my request and if I am unable to adapt to these lenses, standard bifocal lenses will be provided with no additional cost. TN Residents: Please see Instruction 6. Patient Signature Date of Service B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. TN Providers: Please see instruction 6. Authorized Signature Authorized Signature Invoice No. Invoice No. Invoice No. Invoice No. Invoice No. Interest full responsibility for the full responsibility for payment of any charge associated with any of the items selected. I understand that Progressive Addition Lenses will be provided with no additional cost. The Residents: Please see Instruction 6. Stock the full responsibility for policy full and the policy full responsibility for policy full responsibility. Lenses Plastic Photosensitive Lenses Plastic Photosensitive Lenses in the Stock full separate for dependent children, monocular patients and patients with Rx +/-6.00 or greater. **No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/-6.00 or greater. INSTRUCTIONS: 1. Participating provider must complete sections I,III, V, and VIB. 2. Employee or legal guardian should complete and sign Section VIA. 3. All services rendered should be recorded on a single form. 4. Authorization is valid for 21 days. If expired, call 1-800-773-2847 prior to rendering services. 5. Completed forms must be maintained for a period of not less than seven (7) years. 6. Tenne | | Premium ARC | | | \$48 | \$ 7 | |
| Progressive Addition Lenses will be furnished upon my request and if I am unable to adapt to these lenses, standard bifocal lenses will be provided with no additional cost. TN Residents: Please see Instruction 6. Patient Signature | items and costs as outlined in Sections IV and V, and I bear the full responsibility for | | | | \$60 | \$15 | |
| adapt to these lenses, standard bifocal lenses will be provided with no additional cost. TN Residents: Please see Instruction 6. Patient Signature Date of Service B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. TN Providers: Please see instruction 6. Authorized Signature Authorized Signature Invoice No | | | | | \$75 | \$25 | |
| Patient Signature Date of Service B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. TN Providers: Please see instruction 6. Authorized Signature Invoice No. Invoice No. Plastic Photosensitive Lenses Plastic Photosensitive Lenses D \$65 \$25 *For included Fashion or Designer level frames, an additional \$10 dispense will apply. **No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/-6.00 or greater. *INSTRUCTIONS: 1. Participating provider must complete Sections I,III, V, and VIB. 2. Employee or legal guardian should complete and sign Section VIA. 3. All services rendered should be recorded on a single form. 4. Authorization is valid for 21 days. If expired, call 1-800-773-2847 prior to rendering services. 5. Completed forms must be maintained for a period of not less than seven (7) years. 6. Tennessee state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the | adapt to these lenses, standard bifocal lenses will be provided with no additional cost. | | | | \$55 | \$25 | |
| Date of Service | 1 N Residents: Please see Instruction 6. | | sitive | | \$65 | \$25 | |
| **No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/-6.00 or greater. **No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/-6.00 or greater. **No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/-6.00 or greater. **No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/-6.00 or greater. **No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/-6.00 or greater. **No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/-6.00 or greater. **INSTRUCTIONS: 1. Participating provider must complete Sections I,III, V, and VIB. 2. Employee or legal guardian should complete and sign Section VIA. 3. All services rendered should be recorded on a single form. 4. Authorization is valid for 21 days. If expired, call 1-800-773-2847 prior to rendering services. 5. Completed forms must be maintained for a period of not less than seven (7) years. 6. Tennessee state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the | Patient Signature | *For included Fashion or D | esigner level fram | es. an ad | ditional \$10 dispen | se will annly. | |
| B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. TN Providers: Please see instruction 6. Authorized Signature Authorized Signature Invoice No. Invoice No. B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. TN Providers: Please INSTRUCTIONS: 1. Participating provider must complete Sections I,III, V, and VIB. 2. Employee or legal guardian should complete and sign Section VIA. 3. All services rendered should be recorded on a single form. 4. Authorization is valid for 21 days. If expired, call 1-800-773-2847 prior to rendering services. 5. Completed forms must be maintained for a period of not less than seven (7) years. 6. Tennessee state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the | Date of Service | **No copayment/additional | dispense for depe | , | | 110 | |
| INSTRUCTIONS: Invoice No. Inv | B. I certify that all services were provided by me or by authorized personnel. in | Will fee of Great | • | | | | |
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| Invoice No. 6. Tennessee state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the | Authorized Signature | | | | | | |
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You have specific ERISA appeals rights regarding your vision care benefits. These rights may be obtained in detail by contacting Davis Vision at 1-888-778-7183 or writing to: