

Siemens Enterprise Communication North America

Vision Care Service Record
(This form to be maintained by the provider's office)



SECTION I - PROVIDER/PATIENT SECTION

Employee Name: _____
Employee ID No.: _____
Patient Name: _____
Relationship: Employee ___ Spouse ___ Child ___
Provider's Name: _____
Provider's No.: _____
Authorization No.: SMN _____
Authorization Date: _____

SECTION III - SERVICE SECTION

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 lenses provided: (check all that apply)

1. Plan ☐ Patient's ☐
2. Single Vision ☐ Bifocal ☐ Trifocal ☐

C. Contact Lenses Dispensed:

1. Standard, soft, daily-wear lenses or: ☐
2. 4 multi-packs plan supplied Disposable lenses or: ☐
3. 2 multi-packs plan supplied Planned Replacement lenses ☐
4. **Provider Supplied:** Elective ☐
Medically Necessary ☐

D. Frame Provided:

Plan ☐ Patient's ☐ Provider's ☐

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, however, the copayment (if any) for the Progressive Addition Lenses will not be refunded.. **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. _____

SECTION II - COVERAGE SECTION

Plan Level: Designer
Copayments: Eye examination \$10.00
Frame and/or Spectacle lenses \$10.00
Contact Lenses: Formulary \$10.00
Plan Description: An eye examination (including dilation), frames and spectacle lenses or contact lenses in lieu of eyeglasses. Medically necessary contact lenses may be provided with prior approval.

SECTION IV - ALLOWANCE SECTION

Frame	Spectacle Lenses	Contact Lenses	Medically Necessary Contact lenses
\$130.00 plus 20% discount	N/A	\$130.00 plus 15% discount	Paid in full (prior approval required)

SECTION V - OPTIONS SECTION

Patient charges for selected options.
Additional dispense will be paid by Davis Vision.

Option	<input checked="" type="checkbox"/>	Patient Charge	Additional Dispense
Premier Frame	<input type="checkbox"/>	\$25.00	\$ 5.00
Ultraviolet Coating	<input type="checkbox"/>	\$12.00	\$ 6.00
Scratch-Resistant Coating	<input type="checkbox"/>	\$20.00	\$10.00
Photochromic Lenses	<input type="checkbox"/>	\$20.00	\$10.00
Blended Segments	<input type="checkbox"/>	\$20.00	\$10.00
Intermediate Vision Lenses	<input type="checkbox"/>	\$30.00	\$10.00
Standard Progressive Addition Multifocals	<input type="checkbox"/>	\$50.00	\$30.00
Premium Progressive Addition Multifocals	<input type="checkbox"/>	\$90.00	\$30.00
Polycarbonate Lenses*	<input type="checkbox"/>	\$30.00	\$20.00
Standard ARC (anti-reflective coating)	<input type="checkbox"/>	\$35.00	\$ 7.00
Premium ARC (anti-reflective coating)	<input type="checkbox"/>	\$48.00	\$ 7.00
Ultra ARC (anti-reflective coating)	<input type="checkbox"/>	\$60.00	\$15.00
Polarized Lenses	<input type="checkbox"/>	\$75.00	\$25.00
High Index Lenses	<input type="checkbox"/>	\$55.00	\$25.00
Plastic Photosensitive Lenses	<input type="checkbox"/>	\$65.00	\$25.00

*No copayment/additional dispense for dependent children, monocular members and patients with Rx +/-6.00 or greater.

INSTRUCTIONS:

1. Participating provider must complete Sections 1, 3, 5, and 6B.
2. Employee or legal guardian should complete and sign Section 6A.
3. All services rendered should be recorded on a single form.
4. Authorization is valid for 45 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 company. Penalties include imprisonment, fines and denial of insurance benefits.

SR01450 10/16/08

You have specific ERISA appeals rights regarding your vision care benefits. These rights may be obtained in detail by contacting Davis Vision at 1-800-999-5431 or writing to:

**Quality Assurance Department
P. O. Box 1525
Latham, NY 12110**

Appeals must be made within 180 days of the date of service.