



Contact Lens Benefit and Recruitment Training

Davis Vision Presentation | July 2018



Cutting
edge
approach



Holistic
health
perspective



Advanced
technology

See vision care differently



Innovative
algorithms



25+ possible non-eye-
related health diagnoses

Agenda

1. Service Record Form (SRF)
2. Davis Vision Benefit Designs
3. Reimbursements
4. Examples



Reviewing a Service Record Form

Service Record Form (SRF) identify member's benefit information such as plan level, covered items and copays.

SECTION II – COVERAGE SECTION

Use this section to identify any patient co-pays and coverage. Contact Lens Evaluation/ fitting information can be found under this section.

SECTION III – SERVICE SECTION

Use this section to identify contact lenses coverage for Davis Vision supplied contact lenses via the formulary. If the benefit has Davis Vision supplied contact lenses covered, it will be stated as either Premium Collection Lenses, Standard Collection Lenses, or Collection Lenses and it will state the level of coverage (i.e. 4 multi-packs/ 2 multi-packs **plan supplied**). If the benefit does not have Davis Vision supplied contact lenses via the formulary, then it will be stated as Provider Supplied.

SECTION IV – ALLOWANCE SECTION

Allowance Section provides the monetary dollar amount available for non-plan materials. Allowance amounts may vary by plan.

SECTION II - COVERAGE SECTION		
Plan Level:	Fashion	
Copayments:	Eye examination	\$10
	Frame	\$0
	Spectacle lenses	\$25
	Contact Lenses:	
	Premium Collection lenses - Plan 1	\$0
Plan Description: An eye examination (including dilation), spectacle lenses and a frame or contact lenses in lieu of spectacle lenses. Visually Required contact lenses may be provided with prior approval.		

SECTION III - SERVICE SECTION	
C. Contact Lenses:	
Collection Lenses:	
Evaluation/Fitting	<input type="checkbox"/>
4 multi-packs* plan supplied Disposable lenses or:	<input type="checkbox"/>
2 multi-packs* plan supplied Planned Replacement lenses	<input type="checkbox"/>
Provider Supplied: Evaluation/Fitting: Standard	<input type="checkbox"/>
Elective	<input type="checkbox"/>
Visually Required (prior approval required)	<input type="checkbox"/>

SECTION II - COVERAGE SECTION		
Plan Level:	Fashion	
Copayments:	Eye examination	\$20
	Frame	\$0
	Spectacle lenses	\$0
	Contact Lenses	\$0
	Evaluation/fitting	15% discount
Plan Description: An eye examination (including dilation), spectacle lenses and frame, or contact lenses in lieu of eyeglasses. Visually Required contact lenses may be provided with prior approval.		

SECTION III - SERVICE SECTION	
C. Contact Lenses:	
Provider Supplied: Evaluation/Fitting: Standard	<input type="checkbox"/>
Elective	<input type="checkbox"/>
Visually Required (prior approval required)	<input type="checkbox"/>

Davis Vision Benefit Designs

- Davis Vision has a variety of Contact Lens benefit designs.
- 1) Covered/ Included
 - Davis Vision Contact Lens Collection is included in the benefit. Utilize Davis Vision Contact Lens Formulary.
- 2) Up to \$60.00
 - No Davis Vision Contact Lens Collection available in the benefit.
- 3) 15% Discount
 - No Contact Lens benefit.

Covered and Included Benefits

This type of benefit has Davis Vision Contact Lens Collection that is included in the benefit. These members have the option to utilize the Davis Vision Contact Lens Formulary.

Two types of Contact Lens Formulary

- 1) Premium
- 2) Standard

You can identify if the members benefit has a Contact Lens benefit, and if so, which type, by referring to the members Service Record Form, under Section III.

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:

Premium Collection Lenses - Plan 1:

Evaluation/fitting _____

4 multi-p _____

4 multi-p _____

4 multi-p _____

2 multi-p _____

Provider _____

Elective _____

Visually _____

D. Fram _____

Plan

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:

Collection Lenses:

Evaluation/fitting

Standard, hard, daily-wear lenses

Provider Supplied: Evaluation/Fitting: Standard Specialty

Elective

Visually Required (prior approval required)



Find the right contacts with our standard collection

With the Exclusive Collection of Contact Lenses, some plans offer fully-covered lenses and contact lens services. Ask your provider about the brands below to find the right fit for you.



Find the right contacts with our premium collection

Planned Replacement Includes 2 or 4 boxes, depending on your plan and your provider's recommendations.

Disposable Includes 4 or 8 boxes, depending on your plan and your provider's recommendations.

*The contact lenses listed here are part of the Davis Vision formulary of products, which is subject to change.

Looking for our collection? See what your plan covers by visiting davisvision.com, then call your vision care provider to place your order.

Type	Frequency	Brand	Manufacturer
Planned replacement Includes 2 or 4 boxes, depending on your plan and your provider's recommendations.	Planned Replacement	Biofinity®	CooperVision®
	Planned Replacement	Frequency® Aspheric	CooperVision®
Disposable Includes 2, 4 or 8 boxes, depending on your plan and your provider's recommendations.	2 Week	ACUVUE® 2	Vistakon®
	2 Week	ACUVUE® OASYS®	Vistakon®
	Daily	ClearSight™ 1-Day	CooperVision®
	Daily	1-Day ACUVUE MOIST®	Vistakon®
	Toric (2 Week)	ACUVUE® OASYS® for ASTIGMATISM	Vistakon®
	Toric (2 Week)	Biomedics® Toric	CooperVision®
Multifocal (2 Week)	ACUVUE® OASYS® for PRESBYOPIA	Vistakon®	

*The contact lenses listed here are part of the Davis Vision formulary of products, which is subject to change.

Looking for our collection? See what your plan covers by visiting davisvision.com, then call your vision care provider to place your order.

from VersantHealth™
DV_GLC_PREM_08/2018



Up to \$60.00

This type of benefit does not have the Davis Vision Contact Lens Collection benefit available. These members have the option to utilize their allowance to select their contact lens materials from the provider.

This can be identified by viewing Section III of the member's Service Record Form. It will state "Provider Supplied." As you can see, under section IV, the member has a standard fitting covered in full (where Davis will reimburse up to \$60.00) and a specialty fitting covered only up to \$60.00 with a 15% discount on overage.

SECTION I - PROVIDER/PATIENT SECTION	
Employee Name:	_____
Employee ID No.:	_____
Patient Name:	_____
Relationship:	Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>
Provider's Name:	_____
Provider's No.:	_____
Authorization No.:	FEH _____
Authorization Date:	_____

SECTION II - COVERAGE SECTION	
Plan Level:	Premier
Copayments:	Eye examination \$0 Frame and/or Spectacle lenses \$0 Contact Lenses \$0 Evaluation/fitting \$0
Plan Description:	An eye examination (including dilation), contact lens evaluation/fitting, spectacle lenses and frame, or provider supplied contact lenses in lieu of eyeglasses. Medically necessary contact lenses may be provided with prior approval.

SECTION III - SERVICE SECTION	
A. Examination:	Yes <input type="checkbox"/> No <input type="checkbox"/>
1a. Was examination comprehensive?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1b. Was dilation performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1c. Was this a new patient?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1d. Primary Diagnosis code:	_____
Secondary Diagnosis code (if any):	_____
B. Spectacle lenses provided: (check all that apply)	
1. Plan <input type="checkbox"/> Patient's <input type="checkbox"/>	
2. Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/>	
C. Contact Lenses:	
Provider Supplied: Evaluation/Fitting: Standard <input type="checkbox"/> Specialty <input type="checkbox"/>	
Elective <input type="checkbox"/>	
Medically Necessary (prior approval required) <input type="checkbox"/>	
D. Frame Provided:	
Plan <input type="checkbox"/> Patient's <input type="checkbox"/> Provider's <input type="checkbox"/>	

SECTION IV - ALLOWANCE SECTION				
Frame	Contact Lens Evaluation & Fitting		Contact Lens Material	Medically Necessary Contact Lens Material
	Standard	Specialty		
\$150 plus 20% discount on overage	Paid in Full	Up to \$60 plus 15% discount on overage	\$150 plus 15% discount on overage	up to \$600 (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
Ultraviolet Coating	<input type="checkbox"/>	Included	\$ 6
Scratch-Resistant Coating	<input type="checkbox"/>	Included	N/A
Glass Photochromic Lenses	<input type="checkbox"/>	\$20	\$10
Plastic Photosensitive Lenses	<input type="checkbox"/>	Included	\$25
Blended Segments	<input type="checkbox"/>	\$20	\$10
Intermediate Vision Lenses	<input type="checkbox"/>	\$30	\$10
Standard Progressive	<input type="checkbox"/>		

15% Discount Plan

This type of benefit does not have the Davis Vision Contact Lens Collection benefit available. Instead, these members receive a discount.

This can be identified by viewing Section II of the member's Service Record Form. It will state Contact Lenses Evaluation/ Fitting X% discount and under Section III Contact Lenses: Provider Supplied. Since this plan offers only provider supplied contact lens materials, provider must apply members Allowance found under Section IV.

SECTION III - SERVICE SECTION			
A. Examination:	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
1a. Was examination comprehensive?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
1b. Was dilation performed?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
1c. Was this a new patient?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
1d. Primary Diagnosis code:	_____		
Secondary Diagnosis code (if any):	_____		
B. Spectacle lenses provided: (check all that apply)			
1. Plan	<input type="checkbox"/>	Patient's	<input type="checkbox"/>
2. Single Vision	<input type="checkbox"/>	Bifocal	<input type="checkbox"/>
		Trifocal	<input type="checkbox"/>
C. Contact Lenses:			
Provider Supplied:	Evaluation/Fitting:	Standard	<input type="checkbox"/>
		Specialty	<input type="checkbox"/>
	Elective		<input type="checkbox"/>
	Visually Required (prior approval required)		<input type="checkbox"/>
D. Frame Provided:			
	Plan	<input type="checkbox"/>	Patient's <input type="checkbox"/>
			Provider's <input type="checkbox"/>

SECTION II - COVERAGE SECTION		
Plan Level:	Fashion	
Copayments:	Eye examination	\$20
	Frame	\$0
	Spectacle lenses	\$0
	Contact Lenses	\$0
	Evaluation/fitting	15% discount
Plan Description:		
An eye examination (including dilation), spectacle lenses and frame, or contact lenses in lieu of eyeglasses. Visually Required contact lenses may be provided with prior approval.		

SECTION IV - ALLOWANCE SECTION		
Frame	Contact Lens Material	Visually Required Contact Lens Material
\$95 plus 20% discount off overage	\$100 plus 15% discount off overage	Paid in full (prior approval required)

Davis Reimburses Up to \$60.00

Davis does NOT Reimburse

SECTION II - COVERAGE SECTION		
Plan Level:	Premier	
Copayments:	Eye examination	\$0
	Frame** and/or Spectacle lenses	\$0
Contact Lenses:	Contact Lenses:	\$0
	Evaluation/fitting	\$0
Plan Description:	An eye examination (including dilation), contact lens evaluation/fitting, spectacle lenses and frame, or contact lenses in lieu of eyeglasses. Medically necessary contact lenses may be provided with prior approval. The contact lens evaluation/fitting is covered only in conjunction with the contact lens material benefit.	

SECTION II - COVERAGE SECTION		
Plan Level:	Fashion	
Copayments:	Eye examination	\$25
	Frame	\$0
	Spectacle lenses	\$0
	Contact Lenses	\$0
	Evaluation/fitting	15% discount
Plan Description:	An eye examination (including dilation), spectacle lenses and frame, or contact lenses in lieu of eyeglasses. Visually Required contact lenses may be provided with prior approval.	

Three Steps to Identifying Reimbursements



Benefit/ Coverage

First: Look at Section III to determine if there is a Davis Contact Lens Collection benefit coverage



Co-pays

Second: Look at Section II to determine member co-pays and other charges



Davis Vision Formulary

Third: If there is Coverage from Davis Vision formulary, then determine where materials are supplied from and when to apply allowance

User-Friendly Steps

Examples

Davis Vision Covered Benefit: Example 1

Member has Davis Vision CL coverage and Eval and Fitting is covered regardless of DV Supplied or Provider Supplied.



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



Step 1:

Section III, highlighted in yellow, identifies that the benefit has Davis Vision Collection Contacts covered as part of the member's benefit. Coverage level is identified as Premium.

Step 2:

Section II indicates that for an Evaluation/ Fitting there is a co-pay

Step 3:

Based on evaluation, determine where materials will be supplied from (i.e. Davis Vision Formulary or Provider Supplied). If contact lens materials are provider supplied, then Section IV will take effect. In the this example, the member's Evaluation/ Fitting is paid in full (up to \$60.00) by Davis Vision if it was a Standard fit. If the member received a Specialty fit, then Davis will cover up to \$60.00 of the provider's U& C charges. Any overage is member responsibility minus 15%. Provider must then utilize member's contact lens material allowance towards the purchase of contact lens materials.

*Standard Fit is spherical contact lens

** Specialty Fit is toric contact lens, monovision, and multifocal.

SECTION I - PROVIDER/PATIENT SECTION	
Employee Name:	_____
Employee ID No.:	_____
Patient Name:	_____
Relationship:	Employee __ Spouse __ Child __
Provider's Name:	_____
Provider's No.:	_____
Authorization No.:	FEH _____
Authorization Date:	_____

SECTION III - SERVICE SECTION	
A. Examination:	Yes <input type="checkbox"/> No <input type="checkbox"/>
1a. Was examination comprehensive?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1b. Was dilation performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1c. Was this a new patient?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1d. Primary Diagnosis code:	_____
Secondary Diagnosis code (if any):	_____
B. Spectacle lenses provided: (check all that apply)	
1. Plan <input type="checkbox"/> Patient's <input type="checkbox"/>	
2. Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/>	
C. Contact Lenses:	
Provider Supplied: Evaluation/Fitting: Standard <input type="checkbox"/> Specialty <input type="checkbox"/>	
Elective <input type="checkbox"/>	
Medically Necessary (prior approval required) <input type="checkbox"/>	
D. Frame Provided:	
Plan <input type="checkbox"/> Patient's <input type="checkbox"/> Provider's <input type="checkbox"/>	

SECTION II - COVERAGE SECTION	
Plan Level:	Premier
Copayments:	Eye examination \$0
	Frame and/or Spectacle lenses \$0
	Contact Lenses \$0
	Evaluation/fitting \$0
Plan Description:	An eye examination (including dilation), contact lens evaluation/fitting, spectacle lenses and frame, or provider supplied contact lenses in lieu of eyeglasses. Medically necessary contact lenses may be provided with prior approval.

SECTION IV - ALLOWANCE SECTION				
Frame	Contact Lens Evaluation & Fitting		Contact Lens Material	Medically Necessary Contact Lens Material
	Standard	Specialty		
\$150 plus 20% discount on overage	Paid in Full	Up to \$60 plus 15% discount on overage	\$150 plus 15% discount on overage	up to \$600 (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
Ultraviolet Coating	<input type="checkbox"/>	Included	\$ 6
Scratch-Resistant Coating	<input type="checkbox"/>	Included	N/A
Glass Photochromic Lenses	<input type="checkbox"/>	\$20	\$10
Plastic Photosensitive Lenses	<input type="checkbox"/>	Included	\$25
Blended Segments	<input type="checkbox"/>	\$20	\$10
Intermediate Vision Lenses	<input type="checkbox"/>	\$30	\$10
Standard Progressive	<input type="checkbox"/>		

Davis Vision Covered Benefit

Example 1

\$ Provider Reimbursements and Patient Responsibility:

- Section III, highlighted in yellow, identifies that the benefit has Davis Vision Collection Contacts covered as part of the member's benefit. Coverage level is identified as Premium.
- Section II indicates that for an Evaluation/ Fitting there is a co-pay.
- Based on evaluation, determine where materials will be supplied from (i.e. Davis Vision Formulary or Provider Supplied). If contact lens materials are provider supplied, then Section IV will take effect. In the this example, the member's Evaluation/ Fitting is paid in full by Davis Vision if it was a Standard fit. If the member received a Specialty fit, then Davis will cover up to \$60.00 of the provider's U & C charges. Any overage is member responsibility minus 15%. Provider must then utilize member's contact lens material allowance towards the purchase of contact lens materials.

Service	Description	Total Reimbursement	Patient Responsibility (Copays + Additional Patient Responsibility)	Paid by Davis Vision
Evaluation/ Fitting	Contact Lens Materials Supplied from Davis Vision Formulary	Up to \$60.00	\$20.00	Up to \$40.00
Evaluation/ Fitting (Standard)	Contact Lens Materials Supplied by Provider	Up to \$60.00	\$20.00	Up to \$40.00
Evaluation/ Fitting (Specialty)	Contact Lens Materials Supplied by Provider	Up to \$60.00 plus 15% discount on overage of U&C	\$20.00 + 15% discount on overage of U&C	\$40.00
Contact Lens Materials	Contact Lens Materials Supplied from Davis Vision Formulary	\$0.00	\$0.00	\$0.00
Contact Lens Materials	Contact Lens Materials Supplied by Provider	Davis Vision Reimbursement + Patient Responsibility	15% Discount on overage on Member's Allowance	85% of Allowance

Davis Vision Covered Benefit: Example 2

Member has Davis Vision CL coverage and Eval and Fitting is only covered with DV Supplied Lens.



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



Step 1:

Section III, highlighted in yellow, identifies that the benefit has Davis Vision Collection Contacts covered as part of the member's benefit. Coverage level is identified as Premium.

Step 2:

Section II, highlighted in red, will indicate any co-pays for an Evaluation/ Fitting.

Step 3:

Based on evaluation, determine where materials will be supplied from (i.e. Davis Vision Formulary or Provider Supplied). If contact lens materials are Davis Supplied, then the Evaluation/ fitting is covered by Davis Vision. If contact lens materials are provider supplied, then the member's Evaluation/ Fitting is not paid by Davis Vision, and the member receives a 15% discount as indicated under Section II. Provider must then utilize member's contact lens material allowance towards the purchase of contact lens materials as identified under Section IV, highlighted in green.

SECTION I - PROVIDER/PATIENT SECTION	
Employee Name:	_____
Employee ID No.:	_____
Patient Name:	_____
Relationship:	Employee __ Spouse __ Child __
Provider's Name:	_____
Provider's No.:	_____
Authorization No.:	FEH _____
Authorization Date:	_____

SECTION II - COVERAGE SECTION									
Plan Level:	Premier								
Copayments:	<table> <tr> <td>Eye examination</td> <td>\$0</td> </tr> <tr> <td>Frame and/or Spectacle lenses</td> <td>\$0</td> </tr> <tr> <td>Contact Lenses</td> <td>\$0</td> </tr> <tr> <td>Evaluation/fitting</td> <td>\$0</td> </tr> </table>	Eye examination	\$0	Frame and/or Spectacle lenses	\$0	Contact Lenses	\$0	Evaluation/fitting	\$0
Eye examination	\$0								
Frame and/or Spectacle lenses	\$0								
Contact Lenses	\$0								
Evaluation/fitting	\$0								
Plan Description:	An eye examination (including dilation), contact lens evaluation/fitting, spectacle lenses and frame, or provider supplied contact lenses in lieu of eyeglasses. Medically necessary contact lenses may be provided with prior approval.								

SECTION III - SERVICE SECTION	
A. Examination:	Yes <input type="checkbox"/> No <input type="checkbox"/>
1a. Was examination comprehensive?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1b. Was dilation performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1c. Was this a new patient?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1d. Primary Diagnosis code:	_____
Secondary Diagnosis code (if any):	_____
B. Spectacle lenses provided: (check all that apply)	
1. Plan <input type="checkbox"/> Patient's <input type="checkbox"/>	
2. Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/>	
C. Contact Lenses:	
Provider Supplied: Evaluation/Fitting: Standard <input type="checkbox"/> Specialty <input type="checkbox"/>	
Elective	<input type="checkbox"/>
Medically Necessary (prior approval required)	<input type="checkbox"/>
D. Frame Provided:	
Plan <input type="checkbox"/> Patient's <input type="checkbox"/> Provider's <input type="checkbox"/>	

SECTION IV - ALLOWANCE SECTION				
Frame	Contact Lens Evaluation & Fitting		Contact Lens Material	Medically Necessary Contact Lens Material
	Standard	Specialty		
\$150 plus 20% discount on overage	Paid in Full	Up to \$60 plus 15% discount on overage	\$150 plus 15% discount on overage	up to \$600 (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
Ultraviolet Coating	<input type="checkbox"/>	Included	\$ 6
Scratch-Resistant Coating	<input type="checkbox"/>	Included	N/A
Glass Photochromic Lenses	<input type="checkbox"/>	\$20	\$10
Plastic Photosensitive Lenses	<input type="checkbox"/>	Included	\$25
Blended Segments	<input type="checkbox"/>	\$20	\$10
Intermediate Vision Lenses	<input type="checkbox"/>	\$30	\$10
Standard Progressive	<input type="checkbox"/>		

Davis Vision Covered Benefit

Example 2

Provider Reimbursements and Patient Responsibility:

- Section III, highlighted in yellow, identifies that the benefit has Davis Vision Collection Contacts covered as part of the member's benefit. Coverage level is identified as Premium.
- Section II will indicate any co-pays for an Evaluation/ Fitting.
- Based on evaluation, determine where materials will be supplied from (i.e. Davis Vision Formulary or Provider Supplied). If contact lens materials are Davis Supplied, then the Evaluation/ fitting is covered by Davis Vision. If contact lens materials are provider supplied, then the member's Evaluation/ Fitting is not paid by Davis Vision, and the member receives a 15% discount as indicated under Section II. Provider must then utilize member's contact lens material allowance towards the purchase of contact lens materials as identified under Section IV.

Service	Description	Total Reimbursement	Patient Responsibility (Copays + Additional Patient Responsibility)	Paid by Davis Vision
Evaluation/ Fitting	Contact Lens Materials Supplied from Davis Vision Formulary	Up to \$60.00	\$0.00	Up to \$60.00
Evaluation/ Fitting	Contact Lens Materials Supplied by Provider	15% Discount on U&C	15% Discount on U&C	\$0.00
Contact Lens Materials	Contact Lens Materials Supplied from Davis Vision Formulary	\$0.00	\$0.00	\$0.00
Contact Lens Materials	Contact Lens Materials Supplied by Provider	Davis Vision Reimbursement + Patient Responsibility	15% Discount on overage of Member's Allowance	85% of Allowance

Davis Vision Covered Benefit: Example 3

Member has Davis Vision CL coverage and Eval and Fitting is covered when CL is DV Supplied. If Provider Supplied, Eval and Fitting can be pulled from Allowance.

Step 1:


Section III, highlighted in yellow, identifies that the benefit has Davis Vision Collection Contacts covered as part of the member's benefit. Coverage level is identified as Standard.


Step 2:

Section II, highlighted in red, will indicate any co-pays for an Evaluation/ Fitting.

Step 3:

Based on evaluation, determine where materials will be supplied from (i.e. Davis Vision Formulary or Provider Supplied). If contact lens materials are Davis Supplied, then the Evaluation/ fitting is covered by Davis Vision. If contact lens materials are provider supplied, then the member's Evaluation/ Fitting is not paid by Davis Vision, and the member may utilize the allowance towards contact lens evaluations and fitting and the purchase of contact lens materials. This can be identified under Section IV, highlighted in green, with the statement "Contact Lens". Since it states "Contact Lens" the benefit is splittable between evaluation/ fitting and materials. If the statement says "Contact Lens Material", then the allowance can only be utilized for contact lens materials and not applied towards evaluation/ fitting.



BlueCross
BlueShield


FEPBlueVision

FEP Blue Vision

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.: FEH _____				
Authorization Date: _____				

SECTION II - COVERAGE SECTION				
Plan Level:	Premier			
Copayments:	Eye examination	\$0		
	Frame and/or Spectacle lenses	\$0		
	Contact Lenses	\$0		
	Evaluation/fitting	\$0		
Plan Description:	An eye examination (including dilation), contact lens evaluation/fitting, spectacle lenses and frame, or provider supplied contact lenses in lieu of eyeglasses. Medically necessary contact lenses may be provided with prior approval.			

SECTION IV - ALLOWANCE SECTION				
Frame	Contact Lens Evaluation & Fitting		Contact Lens Material	Medically Necessary Contact Lens Material
	Standard	Specialty		
\$150 plus 20% discount on overage	Paid in Full	Up to \$60 plus 15% discount on overage	\$150 plus 15% discount on overage	up to \$600 (prior approval required)

SECTION III - SERVICE SECTION				
A. Examination:				
	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
1a. Was examination comprehensive?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
1b. Was dilation performed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
1c. Was this a new patient?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
1d. Primary Diagnosis code:	_____			
	Secondary Diagnosis code (if any): _____			
B. Spectacle lenses provided: (check all that apply)				
1. Plan	<input type="checkbox"/>	Patient's	<input type="checkbox"/>	
2. Single Vision	<input type="checkbox"/>	Bifocal	<input type="checkbox"/>	Trifocal <input type="checkbox"/>
C. Contact Lenses:				
Provider Supplied:	Evaluation/Fitting:	Standard <input type="checkbox"/>	Specialty <input type="checkbox"/>	
	Elective	<input type="checkbox"/>		
	Medically Necessary (prior approval required)	<input type="checkbox"/>		
D. Frame Provided:				
	Plan <input type="checkbox"/>	Patient's <input type="checkbox"/>	Provider's	<input type="checkbox"/>

SECTION V - OPTIONS SECTION			
Patient charges for selected options. Additional dispense will be paid by Davis Vision.			
Option	☑	Patient Charge	Additional Dispense
Ultraviolet Coating	<input type="checkbox"/>	Included	\$ 6
Scratch-Resistant Coating	<input type="checkbox"/>	Included	N/A
Glass Photochromic Lenses	<input type="checkbox"/>	\$20	\$10
Plastic Photosensitive Lenses	<input type="checkbox"/>	Included	\$25
Blended Segments	<input type="checkbox"/>	\$20	\$10
Intermediate Vision Lenses	<input type="checkbox"/>	\$30	\$10
Standard Progressive	<input type="checkbox"/>		

Allowance is Splitable

Allowance is NOT Splitable

SECTION IV - ALLOWANCE SECTION	
Contact Lens	Visually Required Contact Lenses
\$200	\$600 (prior approval required)

SECTION IV - ALLOWANCE SECTION		
Frame	Contact Lens Material	Visually Required Contact Lens Material
\$60	\$85	Paid in full (prior approval required)

Davis Vision Covered Benefit

Example 3

\$ Provider Reimbursements and Patient Responsibility:

- Section III, highlighted in yellow, identifies that the benefit has Davis Vision Collection Contacts covered as part of the member’s benefit. Coverage level is identified as Premium.
- Section II, highlighted in red, will indicate any co-pays for an Evaluation/ Fitting.
- Based on evaluation, determine where materials will be supplied from (i.e. Davis Vision Formulary or Provider Supplied). If contact lens materials are Davis Supplied, then the Evaluation/ fitting is covered by Davis Vision. If contact lens materials are provider supplied, then the member’s Evaluation/ Fitting is not paid by Davis Vision, and the member may utilize a the allowance towards either the purchase of contact lens material or apply it to the Evaluation/ fitting. Since Section II does not state “Evaluation/ fitting with provider supplied 15% discount” or any other amount, the provider is able to utilize the member’s allowance identified under Section IV, highlighted in green, towards the purchase of contact lens materials or Evaluation/ fitting (i.e. Member allowance is splittable between Evaluation/ fitting and purchase of materials).

Service	Description	Total Reimbursement	Patient Responsibility (Copays + Additional Patient Responsibility)	Paid by Davis Vision
Evaluation/ Fitting	Contact Lens Materials Supplied from Davis Vision Formulary	Up to \$60.00	\$0.00	Up to \$60.00
Evaluation/ Fitting	Contact Lens Materials Supplied by Provider	U&C Pulled from Allowance	\$0.00	\$0.00
Contact Lens Materials	Contact Lens Materials Supplied from Davis Vision Formulary	\$0.00	\$35.00	\$0.00
Contact Lens Materials	Contact Lens Materials Supplied by Provider	Utilize Remainder of Allowance	\$35.00	\$0.00

Up to \$60.00: Example 1

Member does not have Davis Vision CL coverage. Eval and Fitting is covered through separated Allowance based on type of fit.

Step 1:

Section III, highlighted in yellow, identifies that the benefit does not have Davis Vision Collection Contacts covered as part of the member's benefit. Only Provider Supplied Contact are covered.

Step 2:


Section II, highlighted in red, indicates any co-pays for Evaluation/Fitting.

Step 3:

Based on evaluation, determine whether the member received a Standard fit or Specialty fit. Use Section IV, highlighted in green, to calculate your reimbursement. In this example, for a Standard fit the member's Evaluation/ Fitting is paid in full by Davis Vision. If the member received a Specialty fit, then Davis will cover up to \$60.00 of the provider's U&C charges. Any overage is the member's responsibility minus 15%. Provider may then refer to the contact lens materials allowance for the purchase of contact lens materials.

*Standard Fit is spherical contact lens

** Specialty Fit is toric contact lens, monovision, and multifocal



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Vision Care Service Record

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

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SECTION I - PROVIDER/PATIENT SECTION				
Employee Name: _____				
Employee ID No.: _____				
Patient Name: _____				
Relationship: Employee __ Spouse __ Child __				
Provider's Name: _____				
Provider's No.: _____				
Authorization No.: FEH _____				
Authorization Date: _____				

SECTION II - COVERAGE SECTION				
Plan Level:	Premier			
Copayments:	Eye examination	\$0		
	Frame and/or Spectacle lenses	\$0		
	Contact Lenses	\$0		
	Evaluation/fitting	\$0		
Plan Description:	An eye examination (including dilation), contact lens evaluation/fitting, spectacle lenses and frame, or provider supplied contact lenses in lieu of eyeglasses. Medically necessary contact lenses may be provided with prior approval.			

SECTION IV - ALLOWANCE SECTION				
Frame	Contact Lens Evaluation & Fitting		Contact Lens Material	Medically Necessary Contact Lens Material
	Standard	Specialty		
\$150 plus 20% discount on overage	Paid in Full	Up to \$60 plus 15% discount on overage	\$150 plus 15% discount on overage	up to \$600 (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
Ultraviolet Coating	<input type="checkbox"/>	Included	\$ 6
Scratch-Resistant Coating	<input type="checkbox"/>	Included	N/A
Glass Photochromic Lenses	<input type="checkbox"/>	\$20	\$10
Plastic Photosensitive Lenses	<input type="checkbox"/>	Included	\$25
Blended Segments	<input type="checkbox"/>	\$20	\$10
Intermediate Vision Lenses	<input type="checkbox"/>	\$30	\$10
Standard Progressive	<input type="checkbox"/>		

SECTION III - SERVICE SECTION	
A. Examination:	Yes <input type="checkbox"/> No <input type="checkbox"/>
1a. Was examination comprehensive?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1b. Was dilation performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1c. Was this a new patient?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1d. Primary Diagnosis code: _____	
Secondary Diagnosis code (if any): _____	
B. Spectacle lenses provided: (check all that apply)	
1. Plan <input type="checkbox"/> Patient's <input type="checkbox"/>	
2. Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/>	
C. Contact Lenses:	
Provider Supplied: Evaluation/Fitting: Standard <input type="checkbox"/> Specialty <input type="checkbox"/>	
Elective <input type="checkbox"/>	
Medically Necessary (prior approval required) <input type="checkbox"/>	
D. Frame Provided:	
Plan <input type="checkbox"/> Patient's <input type="checkbox"/> Provider's <input type="checkbox"/>	

Up to \$60.00

Example 1

\$ Provider Reimbursements and Patient Responsibility:

- Section III, highlighted in yellow, identifies that the benefit does not have Davis Vision Collection Contacts covered as part of the member's benefit. Only Provider Supplied Contact are covered.
- Section II, highlighted in red, indicates any co-pays for Evaluation/ Fitting.
- Based on evaluation, determine whether the member received a Standard fit or Specialty fit. Use Section IV, highlighted in green, to determine/ calculate your reimbursement. In the this example, for a Standard fit, the member's Evaluation/ Fitting is paid in full by Davis Vision. If the member received a Specialty fit, then Davis will cover **up to** \$60.00 of the provider's U& C charges. Any overage is the member's responsibility minus 15%. Provider may then refer to the contact lens materials allowance and apply that towards the purchase of contact lens materials.

Service	Description	Total Reimbursement	Patient Responsibility (Copays + Additional Patient Responsibility)	Paid by Davis Vision
Evaluation/ Fitting (Standard)	Contact Lens Materials Supplied by Provider	Up to \$60.00	\$0.00	Up to \$60.00
Evaluation/ Fitting (Specialty)	Contact Lens Materials Supplied by Provider	Up to \$60.00 plus 15% discount on overage of U&C	15% Discount on Overage of U&C	Up to \$60.00
Contact Lens Materials	Contact Lens Materials Supplied by Provider	Davis Vision Reimbursement + Patient Responsibility	15% Discount on Overage of U&C	85% of Allowance

Up to \$60.00: Example 2

Member does not have Davis Vision CL coverage. Eval and Fitting is covered through separated Allowance based on type of fit.

Step 1:


Section III, highlighted in yellow, identifies that the benefit does not have Davis Vision Collection Contacts covered as part of the member's benefit. Only Provider Supplied Contact are covered.

Step 2:

Section II, highlighted in red, indicates any co-pays for Evaluation/Fitting.

Step 3:

Use Section IV, highlighted in green, to calculate your reimbursement. In the this example, Evaluation/ Fitting is paid by Davis Vision up to \$40.00 . Patients will be responsible for the overage minus a 15% discount. Provider may then refer to the contact lens materials allowance and apply that towards the purchase of contact lens materials.



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

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SECTION I - PROVIDER/PATIENT SECTION				
Employee Name: _____				
Employee ID No.: _____				
Patient Name: _____				
Relationship: Employee __ Spouse __ Child __				
Provider's Name: _____				
Provider's No.: _____				
Authorization No.: FEH _____				
Authorization Date: _____				

SECTION II - COVERAGE SECTION				
Plan Level:	Premier			
Copayments:	Eye examination	\$0		
	Frame and/or Spectacle lenses	\$0		
	Contact Lenses	\$0		
	Evaluation/fitting	\$0		
Plan Description:	An eye examination (including dilation), contact lens evaluation/fitting, spectacle lenses and frame, or provider supplied contact lenses in lieu of eyeglasses. Medically necessary contact lenses may be provided with prior approval.			

SECTION IV - ALLOWANCE SECTION				
Frame	Contact Lens Evaluation & Fitting		Contact Lens Material	Medically Necessary Contact Lens Material
	Standard	Specialty		
\$150 plus 20% discount on overage	Paid in Full	Up to \$60 plus 15% discount on overage	\$150 plus 15% discount on overage	up to \$600 (prior approval required)

SECTION III - SERVICE SECTION				
A. Examination: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Ia. Was examination comprehensive?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Ib. Was dilation performed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Ic. Was this a new patient?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Id. Primary Diagnosis code: _____				
Secondary Diagnosis code (if any): _____				
B. Spectacle lenses provided: (check all that apply)				
1. Plan <input type="checkbox"/> Patient's <input type="checkbox"/>				
2. Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/>				
C. Contact Lenses:				
Provider Supplied: Evaluation/Fitting: Standard <input type="checkbox"/> Specialty <input type="checkbox"/>				
Elective <input type="checkbox"/>				
Medically Necessary (prior approval required) <input type="checkbox"/>				
D. Frame Provided:				
Plan <input type="checkbox"/> Patient's <input type="checkbox"/> Provider's <input type="checkbox"/>				

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
Ultraviolet Coating	<input type="checkbox"/>	Included	\$ 6
Scratch-Resistant Coating	<input type="checkbox"/>	Included	N/A
Glass Photochromic Lenses	<input type="checkbox"/>	\$20	\$10
Plastic Photosensitive Lenses	<input type="checkbox"/>	Included	\$25
Blended Segments	<input type="checkbox"/>	\$20	\$10
Intermediate Vision Lenses	<input type="checkbox"/>	\$30	\$10
Standard Progressive	<input type="checkbox"/>		

Up to \$60.00

Example 2

\$ Provider Reimbursements and Patient Responsibility:

- Section III, highlighted in yellow, identifies that the benefit does not have Davis Vision Collection Contacts covered as part of the member's benefit. Only Provider Supplied Contact are covered.
- Section II, highlighted in red, indicates any co-pays for Evaluation/ Fitting.
- Use Section IV, highlighted in green, to calculate your reimbursement. In the this example, Evaluation/ Fitting is paid in full by Davis Vision up to \$40.00 . Patients will be responsible for the overage minus a 15% discount. Provider may then refer to the contact lens materials allowance and apply that towards the purchase of contact lens materials.

Service	Description	Total Reimbursement	Patient Responsibility (Copays + Additional Patient Responsibility)	Paid by Davis Vision
Evaluation/ Fitting	Contact Lens Materials Supplied by Provider	Davis Vision Reimbursement + Patient Responsibility	15% Discount on overage of Member's Allowance	Up to \$40.00
Contact Lens Materials	Contact Lens Materials Supplied by Provider	Davis Vision Reimbursement + Patient Responsibility	15% Discount on overage of Member's Allowance	85% of Allowance

15% Discount: Example 1

Member does not have Davis Vision CL coverage for Evaluation/Fitting and Materials.



Step 1:
 Section III, highlighted in yellow, identifies that the benefit does not have Davis Vision Collection Contacts covered as part of the member's benefit. Only Provider Supplied Contact are covered.

Step 2:
 Section II, highlighted in red, indicates there are no co-pays, but instead have a 15% for Evaluation/Fitting.

Step 3:
 Use Section IV, highlighted in green, identifies the contact lens materials allowance and the provider should apply that towards the purchase of contact lens materials.

SECTION I - PROVIDER/PATIENT SECTION	
Employee Name:	_____
Employee ID No.:	_____
Patient Name:	_____
Relationship:	Employee ___ Spouse ___ Child ___
Provider's Name:	_____
Provider's No.:	_____
Authorization No.:	FEH _____
Authorization Date:	_____

SECTION II - COVERAGE SECTION									
Plan Level:	Premier								
Copayments:	<table> <tr> <td>Eye examination</td> <td>\$0</td> </tr> <tr> <td>Frame and/or Spectacle lenses</td> <td>\$0</td> </tr> <tr> <td>Contact Lenses</td> <td>\$0</td> </tr> <tr> <td>Evaluation/fitting</td> <td>\$0</td> </tr> </table>	Eye examination	\$0	Frame and/or Spectacle lenses	\$0	Contact Lenses	\$0	Evaluation/fitting	\$0
Eye examination	\$0								
Frame and/or Spectacle lenses	\$0								
Contact Lenses	\$0								
Evaluation/fitting	\$0								
Plan Description:	An eye examination (including dilation), contact lens evaluation/fitting, spectacle lenses and frame, or provider supplied contact lenses in lieu of eyeglasses. Medically necessary contact lenses may be provided with prior approval.								

SECTION III - SERVICE SECTION	
A. Examination:	Yes <input type="checkbox"/> No <input type="checkbox"/>
1a. Was examination comprehensive?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1b. Was dilation performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1c. Was this a new patient?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1d. Primary Diagnosis code:	_____
Secondary Diagnosis code (if any):	_____
B. Spectacle lenses provided: (check all that apply)	
1. Plan <input type="checkbox"/> Patient's <input type="checkbox"/>	
2. Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/>	
C. Contact Lenses:	
Provider Supplied: Evaluation/Fitting: Standard <input type="checkbox"/> Specialty <input type="checkbox"/>	
Elective	<input type="checkbox"/>
Medically Necessary (prior approval required)	<input type="checkbox"/>
D. Frame Provided:	
Plan <input type="checkbox"/> Patient's <input type="checkbox"/> Provider's <input type="checkbox"/>	

SECTION IV - ALLOWANCE SECTION				
Frame	Contact Lens Evaluation & Fitting		Contact Lens Material	Medically Necessary Contact Lens Material
	Standard	Specialty		
\$150 plus 20% discount on overage	Paid in Full	Up to \$60 plus 15% discount on overage	\$150 plus 15% discount on overage	up to \$600 (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
Ultraviolet Coating	<input type="checkbox"/>	Included	\$ 6
Scratch-Resistant Coating	<input type="checkbox"/>	Included	N/A
Glass Photochromic Lenses	<input type="checkbox"/>	\$20	\$10
Plastic Photosensitive Lenses	<input type="checkbox"/>	Included	\$25
Blended Segments	<input type="checkbox"/>	\$20	\$10
Intermediate Vision Lenses	<input type="checkbox"/>	\$30	\$10
Standard Progressive	<input type="checkbox"/>		

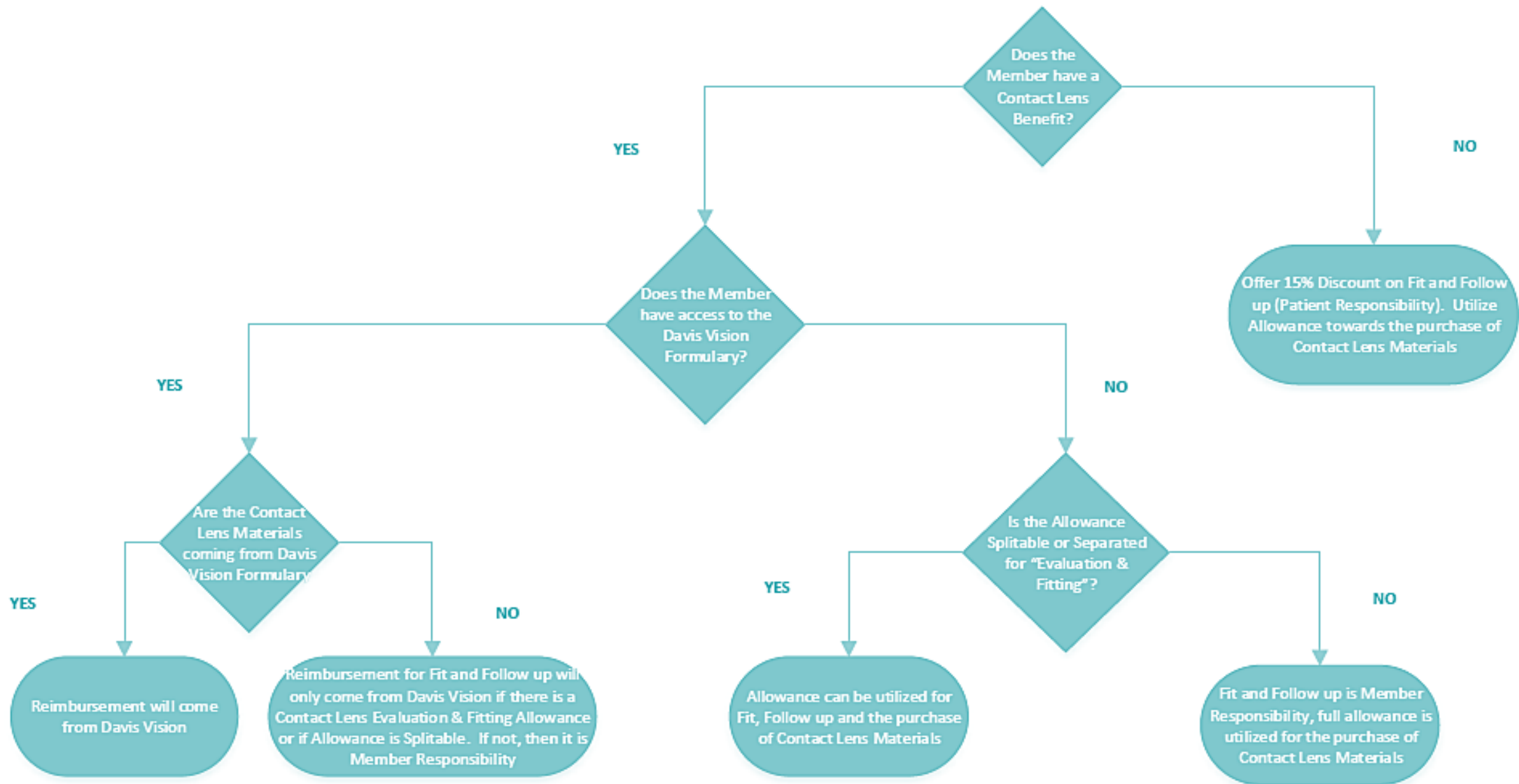
15% Discount

Example 1

Provider Reimbursements and Patient Responsibility:

- Section III, highlighted in yellow, identifies that the benefit does not have Davis Vision Collection Contacts covered as part of the member's benefit. Only Provider Supplied Contact are covered.
- Section II, highlighted in red, indicates there are no co-pays, but instead have a 15% for Evaluation/ Fitting.
- Use Section IV, highlighted in green, identifies the contact lens materials allowance and the provider should apply that towards the purchase of contact lens materials.

Service	Description	Total Reimbursement	Patient Responsibility (Copays + Additional Patient Responsibility)	Paid by Davis Vision
Evaluation/ Fitting	Contact Lens Materials Supplied by Provider	15% of U&C	15% of U&C	\$0.00
Contact Lens Materials	Contact Lens Materials Supplied by Provider	Davis Vision Reimbursement + Patient Responsibility	15% Discount on overage of Member's Allowance	85% of Allowance



CONTACT NUMBERS



Provider Services

1-800-584-3140

Monday – Friday: 8AM – 6PM EST



Utilization Review

1-800-584-2329

Monday – Friday: 8AM – 6PM EST



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