Davis Vision
Explanation of Payment Training

DAVIS VISION PRESENTATION | 2018

Agenda

1. Introduction to the Davis Vision model and plans
2. Service Record Form (SRF)
3. Benefit Alerts
4. Payment Summary
5. Claims Systems
6. Check Group Codes
7. Sample EOPs
8. Examples
9. Appendix

Davis Vision Model and Plans

Integrated Model

Davis Vision has a unique model that is designed to provide an end-to-end solution for members and providers from Frames to Manufacturing

Provider Portal

Easy to navigate online portal that will automatically submit your orders and claims simultaneously

Exclusive Collection

Member benefit give them the choice to select either from the collection or utilize their allowance to purchase a provider supplied frame.

Diverse Membership

Membership ranging from Regional to National, commercial to government, and small and large groups across the US.

Manufacturing

Dedicated multiple manufacturing facilities that manufacture over 300 jobs per hour

Reviewing a Service Record Form

Service Record Form (SRF) identify member's benefit information such as plan level, covered items and copays.
Print the SRF and keep with patient record.

SECTION II – COVERAGE SECTION

Coverage Section provides plan level, benefit cycle detail and basic copays. Plan descriptions may vary by plan.

SECTION III – SERVICE SECTION

Service Section provides the contact lenses coverage for Davis Vision supplied contact lenses via the formulary.

SECTION IV – ALLOWANCE SECTION

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

SECTION V – OPTIONS SECTION

Options Section provides information in regards to copays and surfees.

- Patient Charge: upfront cost received from patient.
- Additional Dispense (Surfee): what providers keep from the service rendered.
  - Difference from Patient Charge and Additional Dispense is Davis Vision Manufacturing Cost.

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	☐
4 multi-packs* plan supplied Disposable lenses or:	☐
2 multi-packs* plan supplied Planned Replacement lenses	☐
Provider Supplied: Evaluation/Fitting: Standard ☐ Specialty	☐
Elective	☐
Visually Required (prior approval required)	☐

SECTION IV - ALLOWANCE SECTION

Frame	Contact Lens Material	Visually Required Contact Lens Material
$130	$130	Paid in full (prior approval required)

SECTION V - OPTIONS SECTION

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

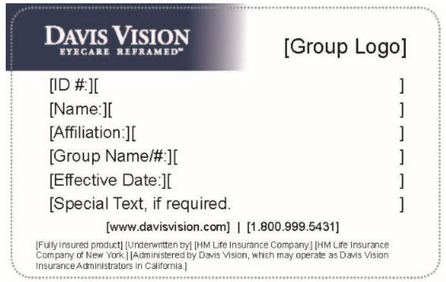
Option	☑	Patient Charge	Additional Dispense
Designer Frame	☐	$20	N/A
Premier Frame	☐	$40	N/A
Tinted Lenses	☐	$11	N/A
Ultraviolet Coating	☐	$12	$ 6

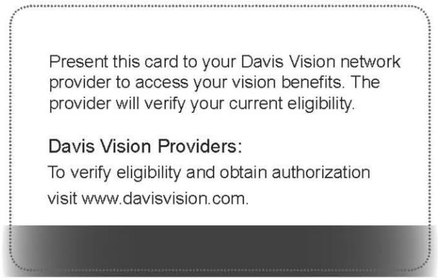
BEST PRACTICE:

Print Service Record Form for Patient's records

Accessing Benefits and Benefit Alerts

1 Retrieve the Member's ID Card





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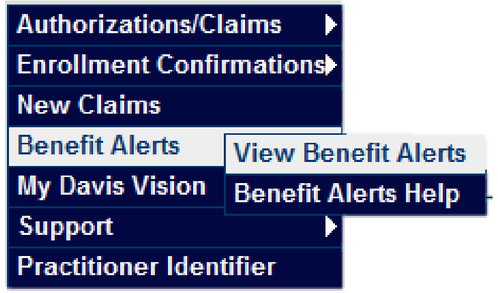
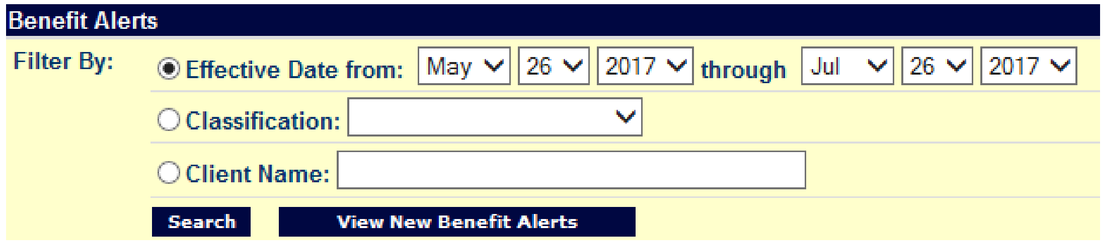
Use Navigation Menu Shortcut

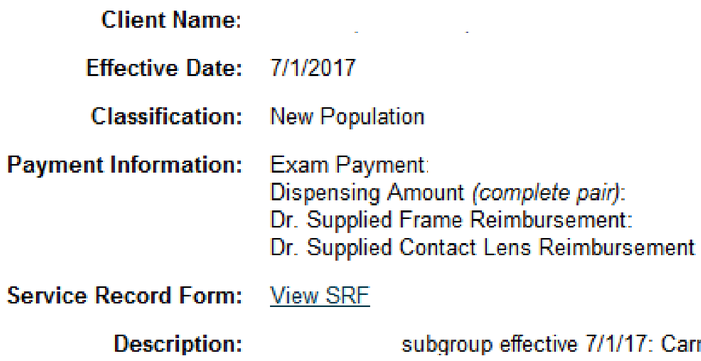


OR

Use Search Criteria Field



3 Review the Benefit Alert



Payment Summary

The Payment Summary includes:

- Invoice Number
- Provider Payments

BEST PRACTICE:

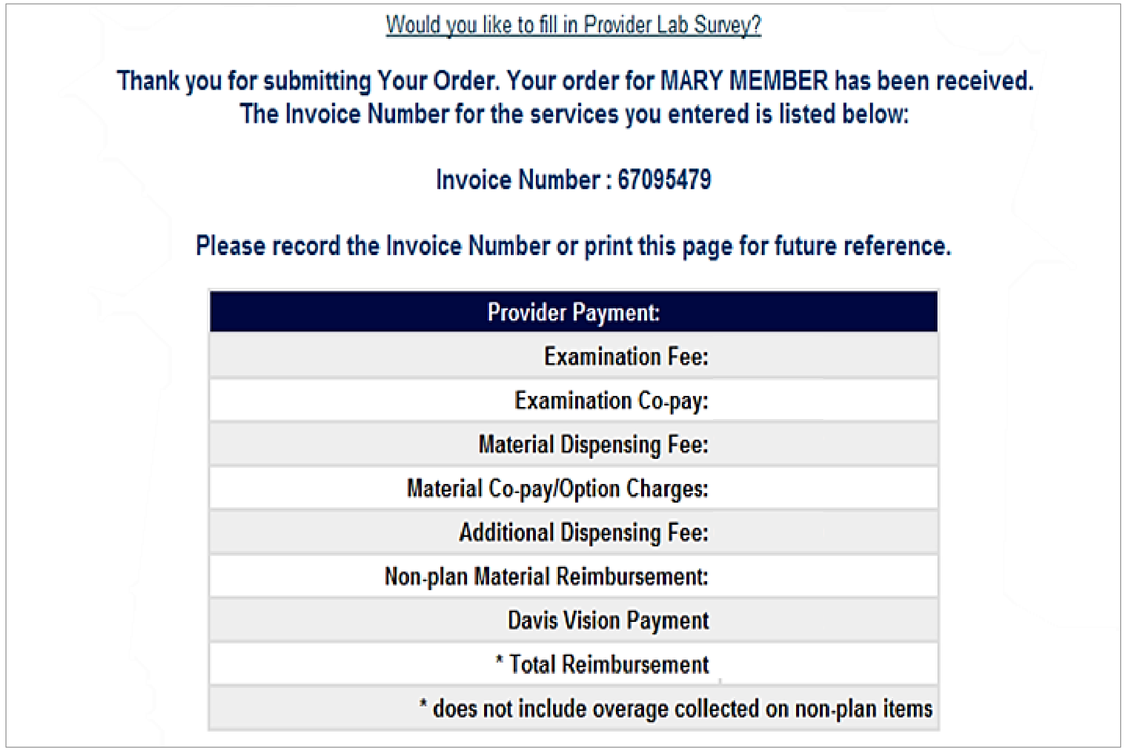
Print payment summary for office records

Attention:
Once you exit this screen, you will no longer have access

Explanation of Payment (EOP)

- Checks are issued every Friday. An EOP will be included inside the envelope.

Key Note: For a breakdown on coding refer to Procedure Codes located in the "Important Links" Menu



Would you like to fill in Provider Lab Survey?

Thank you for submitting Your Order. Your order for MARY MEMBER has been received.
The Invoice Number for the services you entered is listed below:

Invoice Number : 67095479

Please record the Invoice Number or print this page for future reference.

Provider Payment:
Examination Fee:
Examination Co-pay:
Material Dispensing Fee:
Material Co-pay/Option Charges:
Additional Dispensing Fee:
Non-plan Material Reimbursement:
Davis Vision Payment
* Total Reimbursement
* does not include overage collected on non-plan items

Claims System, Procedure Codes and EOPs

Davis Vision Claims are paid through 2 different systems, thus generating 2 different versions of an EOP

CompuVision (CV)

DAVIS VISION PROV# XXXX JONES OPTICAL

DATE: 04/13/2017

VOUCHER NO.	NAME	DOB	PROC	SRV DATE	GROSS	COPAY	SURFEE	NET	ID NUMBER
XXX### XXX########	Patient Name	Date of Birth	001	04072017	46.35	10.00		36.35	*****5832
XXX### XXX########	Patient Name	Date of Birth	001	04052017	46.35			46.35	*****1696
XXX### XXX########	Patient Name	Date of Birth	N06YAZ	04052017	45.75	244.00	95.00	103.25-	*****1696
	TOTAL NET AMOUNT FOR CURRENT PERIOD							20.55-	
	BALANCE FORWARD							117.41-	

TOTAL VOUCHERS 3 TOTAL SERVICES 3 NET AMOUNT 137.96-
AMOUNT NOT POSITIVE - NO CHECK ISSUED

CV is the original program where majority of the plans are housed. Under this system, Davis Vision procedure codes are utilized to identify a claim.

CVX

EXPLANATION OF PAYMENT

DAVIS VISION EYECARE REFRAMED℠

Check No: XXXX **Check Date:** 08/10/2017 **Check Amount:** $82.11
Payable To: Provider Pay to Name
Payee Number: XXXXX

175 East Houston Street
San Antonio, TX 78205

IMPORTANT MESSAGE

For Directory purposes Providers are responsible for proactively notifying Davis Vision of all changes regarding their network status, office information, and professional information. The Provider Add, Change, and Termination Forms may be found on the Davis Vision Provider Portal - https://www.davisvision.com/Provider/

Date of Service	Procedure Code**	Submitted Charges	Allowed Amount	Benefit Allowance	Deductible Amount	Copayment Amount	Coinsurance Amount	Additional Patient Responsibility	Total Patient Responsibility	Total Reimbursement	Paid By Davis Vision	EOP Message
Services Rendered By: Provider Associate **No:** Provider ID Number												
Claim No: XXX######## **Patient Name:** Name of Patient **Member ID:** ID Number												
8/9/17	92002	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$46.35	$36.35	
8/9/17	V2020	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$22.88	$22.88	
8/9/17	V2781	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.00	$15.00	
8/9/17	V2781	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.00	$15.00	
8/9/17	V2203	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$6.44	($3.56)	
8/9/17	V2203	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$6.44	($3.56)	
Claim Total		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$30.00**	**$0.00**	**$0.00**	**$30.00**	**$112.11**	**$82.11**	

Total Patient Responsibility: $30.00 **Total Reimbursement: $112.11** **Check Amount: $82.11**

Total Number of Claims: 1
Check Group Code: PX

Balance Forward: $0.00
Current Activity: $82.11
Ending Balance: $82.11

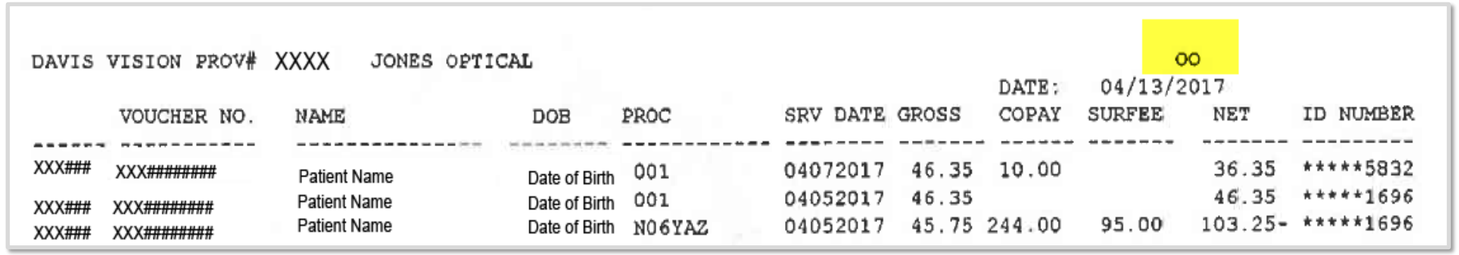
CVX is a more sophisticated program in which CPT codes are utilized to identify a claim.

Check Group Codes

Important Information

- All Davis Vision Plans are placed into one of 19 different check group codes.

DV	NN
EE	NO
EX	NP
FE	OC
GG	OO
IL	OX
IP	PP
IX	PX
MM	TX
	XX

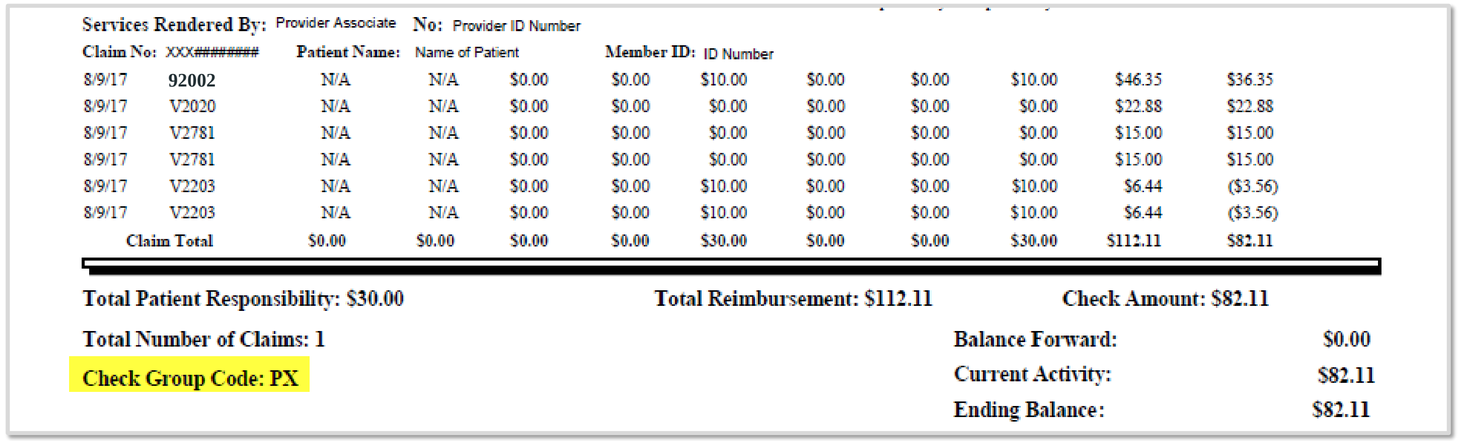


DAVIS VISION PROV# XXXX JONES OPTICAL

OO

DATE: 04/13/2017

VOUCHER NO.	NAME	DOB	PROC	SRV DATE	GROSS	COPAY	SURFEE	NET	ID NUMBER
XXX### XXX########	Patient Name	Date of Birth	001	04072017	46.35	10.00		36.35	*****5832
XXX### XXX########	Patient Name	Date of Birth	001	04052017	46.35			46.35	*****1696
XXX### XXX########	Patient Name	Date of Birth	N06YAZ	04052017	45.75	244.00	95.00	103.25-	*****1696



Services Rendered By: Provider Associate No: Provider ID Number

Claim No: XXX######## Patient Name: Name of Patient Member ID: ID Number

8/9/17	92002	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$46.35	$36.35
8/9/17	V2020	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$22.88	$22.88
8/9/17	V2781	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.00	$15.00
8/9/17	V2781	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.00	$15.00
8/9/17	V2203	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$6.44	($3.56)
8/9/17	V2203	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$6.44	($3.56)
Claim Total		$0.00	$0.00	$0.00	$0.00	$30.00	$0.00	$0.00	$30.00	$112.11	$82.11

Total Patient Responsibility: $30.00 Total Reimbursement: $112.11 Check Amount: $82.11

Total Number of Claims: 1

Check Group Code: PX

Balance Forward: $0.00

Current Activity: $82.11

Ending Balance: $82.11

- Each check group code will generate their own EOP and cannot be combined due to regulatory and Client issues. Thus, you may receive an invoice for one check group code, but have a check for another check group code.

CV EOP

1 Your Davis Vision Provider Information such as Office ID and Office Name

2 Voucher Number: Also is commonly referred to as an Authorization Number

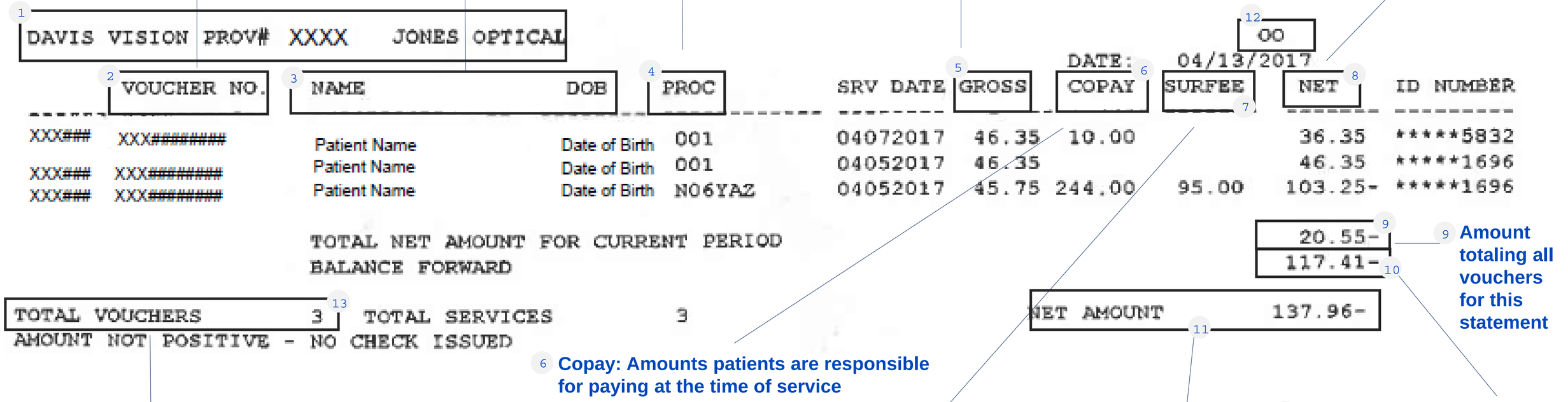
3 Member Information that is related to the Voucher/ Authorization Number

4 Procedure Codes

5 Gross: gross amount may include all or some of the following: Examination, Dispensing, and Non-plan Allowance Fees

12 Check Group code for this statement

8 Net = (Gross + Surfee) - Copay



DAVIS VISION PROV# XXXX JONES OPTICAL

12 00

DATE: 04/13/2017

2 VOUCHER NO.	3 NAME	DOB	4 PROC	SRV DATE	5 GROSS	6 COPAY	7 SURFEE	8 NET	ID NUMBER
XXX### XXX########	Patient Name	Date of Birth	001	04072017	46.35	10.00		36.35	*****5832
XXX### XXX########	Patient Name	Date of Birth	001	04052017	46.35			46.35	*****1696
XXX### XXX########	Patient Name	Date of Birth	NO6YAZ	04052017	45.75	244.00	95.00	103.25-	*****1696

TOTAL NET AMOUNT FOR CURRENT PERIOD 20.55- 9

BALANCE FORWARD 117.41- 10

13 TOTAL VOUCHERS 3 TOTAL SERVICES 3

NET AMOUNT 137.96- 11

AMOUNT NOT POSITIVE - NO CHECK ISSUED

9 Amount totaling all vouchers for this statement

6 Copay: Amounts patients are responsible for paying at the time of service

7 Surfee: any additional dispense fees for frame and lens enhancements (identified as additional dispense on the SRF)

10 Cumulative Negative Balance from previous statement for this check group code

11 Total for the current period minus any Negative Balance from previous statements for this check group code.

13 Total of all vouchers listed above

CVX EOP

2 Your Davis Vision Provider Information

1 Check Information

7 Member's allowance as identified in the SRF

5 Procedure Codes

8 Amount patients are responsible for paying when rendering services found under Section II of the SRF

6 The charges identified in your provider portal by your office

11 Reimbursements paid to the provider less the copay

10 Provider's contractual reimbursement rate

4 Voucher/ Authorization Number

9 Total amount patients are responsible for paying when rendering services. Copays + "Patient Charge" identified under Section V of SRF

3 Member Information

17 Total number of claims filed under this check group code for this statement

13 Total reimbursement less the copay

18 This is where you can find which check group code for this statement

Amount owed to Davis Vison from pervious transactions for this check group code

12 The total contractual reimbursement rates for all patients identified in this statement

16 Check Amount minus the Balance Forward

15 Total Reimbursements minus Total Patient Responsibility

19 Description of the claim filed in the provider portal

EXPLANATION OF PAYMENT

Check No: XXXX **Check Date:** 08/10/2017 **Check Amount:** $82.11 (1)

Payable To: Provider Pay to Name (2)

Payee Number: XXXXX

IMPORTANT MESSAGE

For Directory purposes Providers are responsible for proactively notifying Davis Vision of all changes regarding their network status, office information, and professional information. The Provider Add, Change, and Termination Forms may be found on the Davis Vision Provider Portal - https://www.davisvision.com/Provider/

Services Rendered By: Provider Associate **No:** Provider ID Number

Claim No: XXX######## (4) **Patient Name:** Name of Patient **Member ID:** ID Number (3)

Date of Service	Procedure Code** (5)	Submitted Charges (6)	Allowed Amount	Benefit Allowance (7)	Deductible Amount	Copayment Amount (8)	Coinsurance Amount	Additional Patient Responsibility	Total Patient Responsibility (9)	Total Reimbursement (10)	Paid By Davis Vision (11)	EOP Message
8/9/17	92002	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$46.35	$36.35	
8/9/17	V2020	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$22.88	$22.88	
8/9/17	V2781	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.00	$15.00	
8/9/17	V2781	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.00	$15.00	
8/9/17	V2203	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$6.44	($3.56)	
8/9/17	V2203	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$6.44	($3.56)	
Claim Total		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$30.00**	**$0.00**	**$0.00**	**$30.00**	**$112.11**	**$82.11**	

Total Patient Responsibility: $30.00

Total Reimbursement: $112.11 (12)

Check Amount: $82.11 (13)

Total Number of Claims: 1 (17)

Check Group Code: PX (18)

Balance Forward:	**$0.00** (14)
Current Activity:	**$82.11** (15)
Ending Balance:	**$82.11** (16)

(19)

****Procedure Code Description**

92002 - ROUTINE OPHTH EX W/REFRAC; NEW PT
V2020 - FRAMES PURCHASES
V2203 - BIFOCL PLANO +/-4.00D 0.12-2.00D EA
V2781 - PROGRESSIVE LENS PER LENS

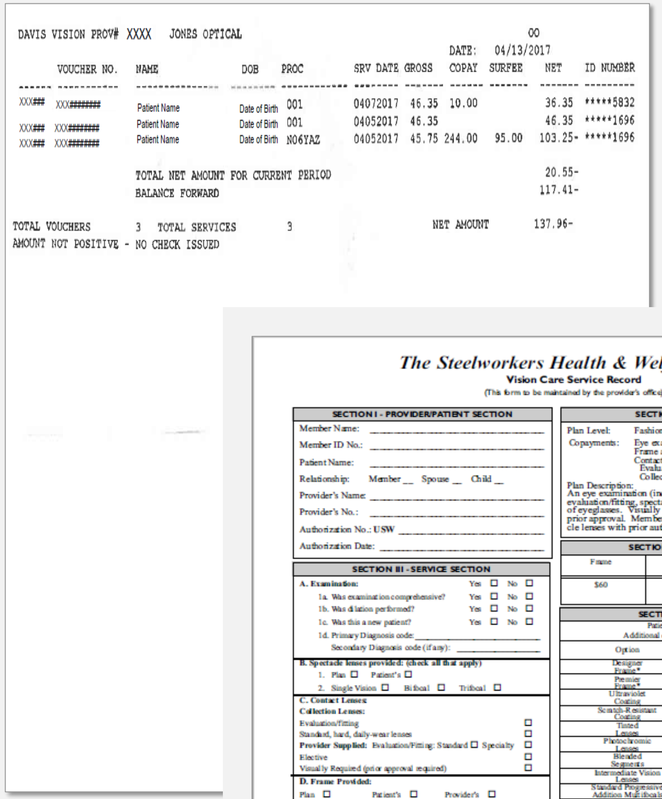
EXAMPLES

User-Friendly Steps

Step 1 (CV)

Pull the following reference documents:

- Copy of EOP
- Copy of the Service Record Form (SRF)
- Davis Vision Procedure/ EOP Codes list
- Benefit Alert
- Payment Summary



DAVIS VISION PROV# XXXX JONES OPTICAL

DATE: 04/13/2017

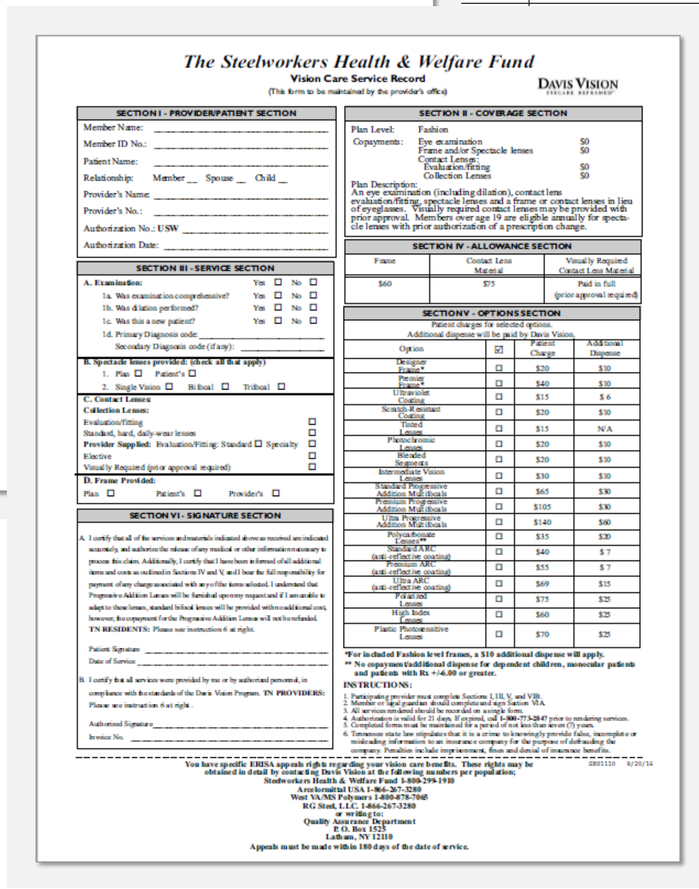
VOUCHER NO.	NAME	DOB	PROC	SRV DATE	GROSS	COPAY	SURFEE	NET	ID NUMBER
XXX## XXX#######	Patient Name	Date of Birth	001	04072017	46.35	10.00		36.35	*****5832
XXX## XXX#######	Patient Name	Date of Birth	001	04052017	46.35			46.35	*****1696
XXX## XXX#######	Patient Name	Date of Birth	N06YAZ	04052017	45.75	244.00	95.00	103.25-	*****1696

TOTAL NET AMOUNT FOR CURRENT PERIOD 20.55-

BALANCE FORWARD 117.41-

TOTAL VOUCHERS 3 TOTAL SERVICES 3 NET AMOUNT 137.96-

AMOUNT NOT POSITIVE - NO CHECK ISSUED



The Steelworkers Health & Welfare Fund

Vision Care Service Record

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

DAVIS VISION EYECARE REFRAMED℠

SECTION I - PROVIDER/PATIENT SECTION

Member Name:
Member ID No.:
Patient Name:
Relationship: Member __ Spouse __ Child __
Provider's Name:
Provider's No.:
Authorization No.: USW
Authorization Date:

SECTION II - COVERAGE SECTION

Plan Level: Fashion

Copayments:

Eye examination	$0
Frame and/or Spectacle lenses	$0
Contact Lenses:	
Evaluation/fitting	$0
Collection Lenses	$0

Plan Description:
An eye examination (including dilation), contact lens evaluation/fitting, spectacle lenses and a frame or contact lenses in lieu of eyeglasses. Visually required contact lenses may be provided with prior approval. Members over age 19 are eligible annually for spectacle lenses with prior authorization of a prescription change.

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) ☐

D. Frame Provided:
Plan ☐ Patient's ☐ Provider's ☐

SECTION IV - ALLOWANCE SECTION

Frame	Contact Lens Material	Visually Required Contact Lens Material
$60	$75	Paid in full (prior approval required)

SECTION V - OPTIONS SECTION

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

Option	☑	Patient Charge	Additional Dispense
Designer Frame*	☐	$20	$30
Premier Frame*	☐	$40	$30
Ultraviolet Coating	☐	$15	$ 6
Scratch-Resistant Coating	☐	$20	$30
Tinted Lenses	☐	$15	N/A
Photochromic Lenses	☐	$20	$30
Blended Segments	☐	$20	$30
Intermediate Vision Lenses	☐	$30	$30
Standard Progressive Addition Multifocals	☐	$65	$30
Premium Progressive Addition Multifocals	☐	$105	$30
Ultra Progressive Addition Multifocals	☐	$140	$60
Polycarbonate Lenses**	☐	$35	$20
Standard ARC (anti-reflective coating)	☐	$40	$ 7
Premium ARC (anti-reflective coating)	☐	$55	$ 7
Ultra ARC (anti-reflective coating)	☐	$69	$15
Polarized Lenses	☐	$75	$25
High Index Lenses	☐	$60	$25
Plastic Photosensitive Lenses	☐	$70	$25

*For included Fashion level frames, a $10 additional dispense will apply.
** No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/-6.00 or greater.

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 without additional cost, however, the copayment for the Progressive Addition Lenses will not be refunded.
TN RESIDENTS: Please see instruction 6 at right.

Patient Signature
Date of Service

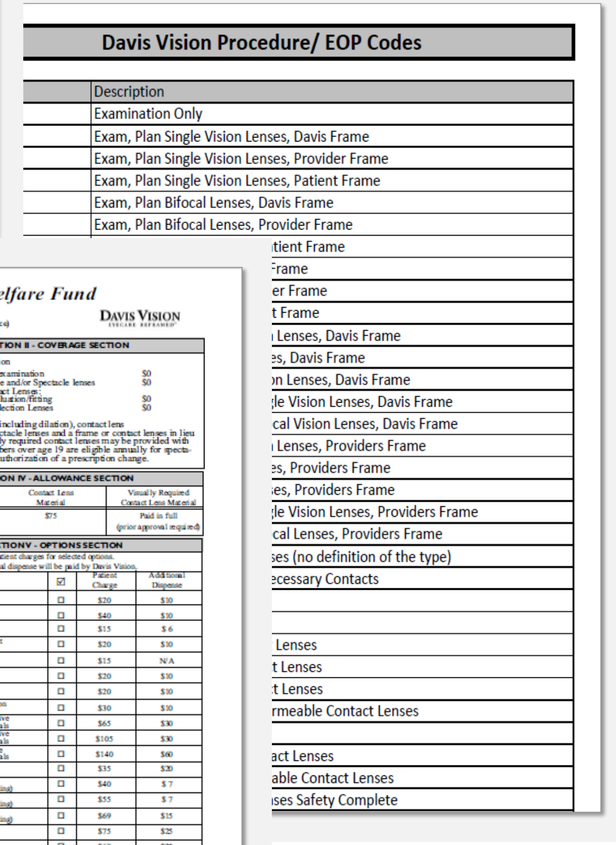
B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. TN PROVIDERS: Please see instruction 6 at right.

Authorized Signature
Invoice No.

INSTRUCTIONS:
1. Participating provider must complete Sections I, III, V, and VI.
2. Member or legal guardian should complete and sign Section VI A.
3. All services rendered should be recorded on acopple form.
4. Authorization is valid for 21 days. If expired, call 1-800-77-3247 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.

You have specific ERISA appeals rights regarding your vision care benefits. These rights may be obtained in detail by contacting Davis Vision at the following numbers per population;
Steelworkers Health & Welfare Fund 1-800-299-1910
Arcelormittal USA 1-866-267-3280
West VA/MS Polymers 1-800-678-7065
RG Steel, LLC 1-866-267-3280
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.

1801110 8/20/14



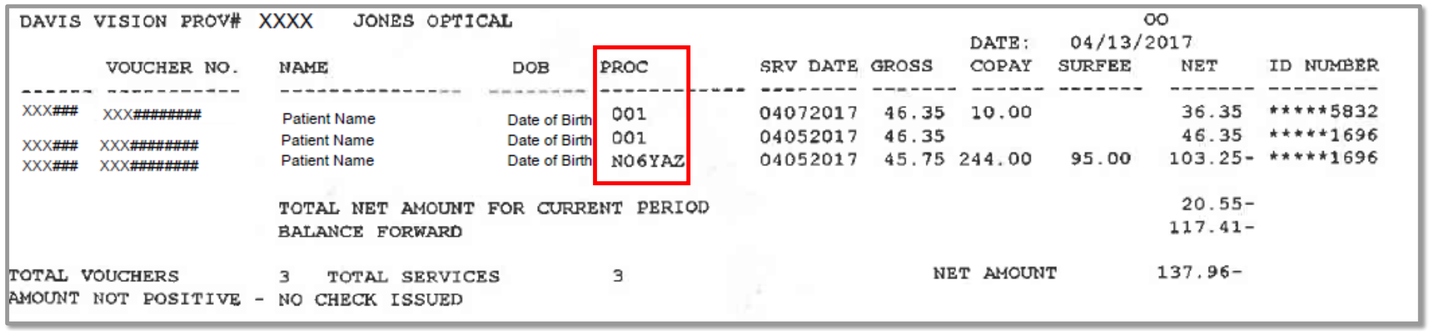
Davis Vision Procedure/ EOP Codes

	Description
	Examination Only
	Exam, Plan Single Vision Lenses, Davis Frame
	Exam, Plan Single Vision Lenses, Provider Frame
	Exam, Plan Single Vision Lenses, Patient Frame
	Exam, Plan Bifocal Lenses, Davis Frame
	Exam, Plan Bifocal Lenses, Provider Frame
	tient Frame
	Frame
	er Frame
	t Frame
	Lenses, Davis Frame
	es, Davis Frame
	n Lenses, Davis Frame
	le Vision Lenses, Davis Frame
	cal Vision Lenses, Davis Frame
	Lenses, Providers Frame
	es, Providers Frame
	es, Providers Frame
	le Vision Lenses, Providers Frame
	cal Lenses, Providers Frame
	es (no definition of the type)
	ecessary Contacts
	Lenses
	t Lenses
	t Lenses
	rmeable Contact Lenses
	act Lenses
	able Contact Lenses
	ses Safety Complete

Step 2 (CV)

Identify Details of the Claim

- Identify the Procedure Code Column on the EOP
- Use the Davis Vision Procedure/ EOP Codes list to identify the subset of the claim
- List out each code individually with their descriptions



DAVIS VISION PROV# XXXX JONES OPTICAL

DATE: 04/13/2017

VOUCHER NO.	NAME	DOB	PROC	SRV DATE	GROSS	COPAY	SURFEE	NET	ID NUMBER
XXX### XXX########	Patient Name	Date of Birth	001	04072017	46.35	10.00		36.35	*****5832
XXX### XXX########	Patient Name	Date of Birth	001	04052017	46.35			46.35	*****1696
XXX### XXX########	Patient Name	Date of Birth	N06YAZ	04052017	45.75	244.00	95.00	103.25-	*****1696

TOTAL NET AMOUNT FOR CURRENT PERIOD 20.55-
BALANCE FORWARD 117.41-

TOTAL VOUCHERS 3 TOTAL SERVICES 3 NET AMOUNT 137.96-
AMOUNT NOT POSITIVE - NO CHECK ISSUED

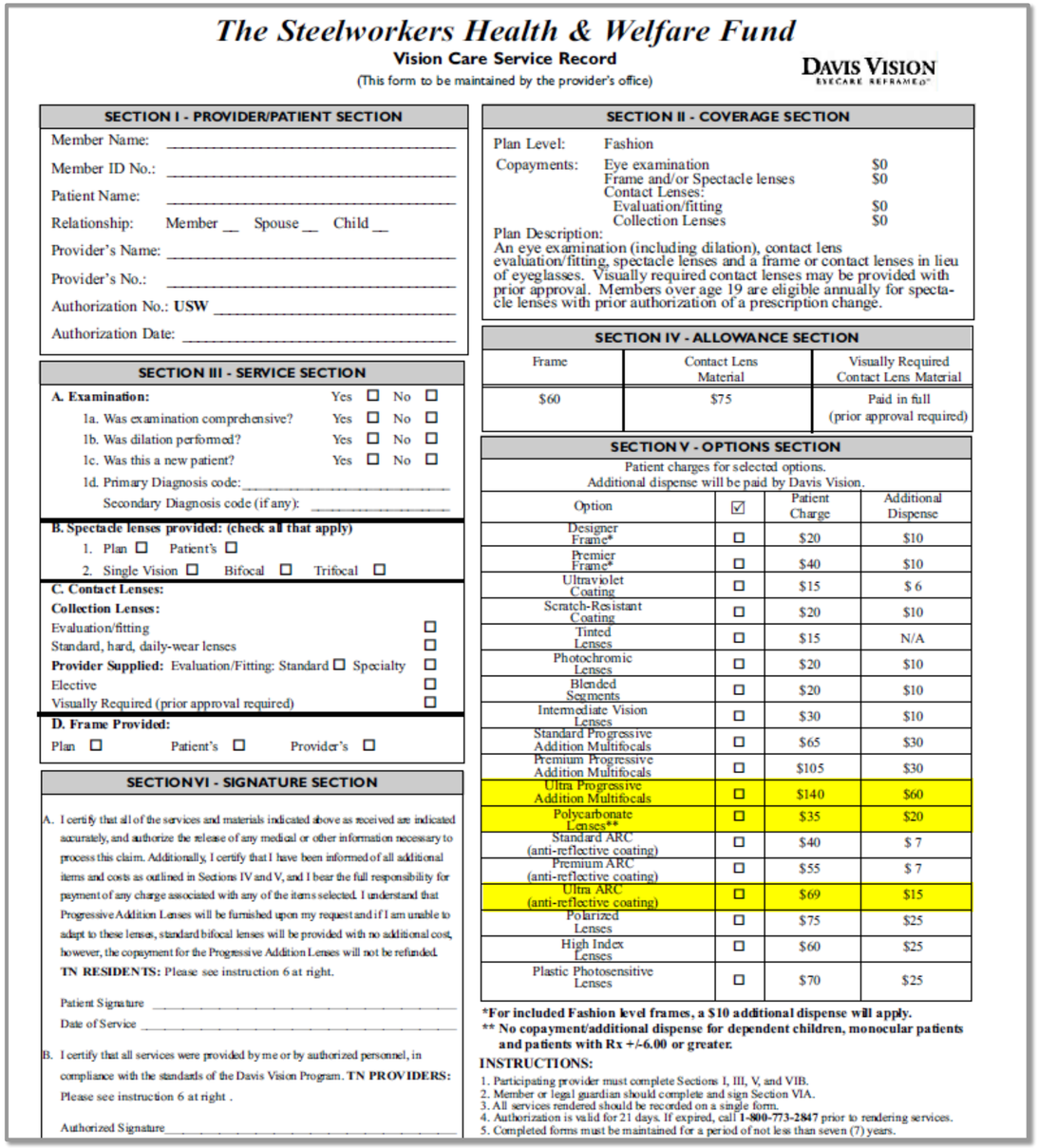
Procedure Code	Description
N06	Bifocal and Provider Supplied Frame
N06	Bifocal and Provider Supplied Frame
Y	Ultra Progressive
A	Polycarbonate Lens
Z	Ultra Anti Reflective Coating
TOTAL	

Step 3 (CV)

$ Identify Reimbursements

- List the reimbursements in their designated columns
- Using the Service Record Form, highlight all options chosen by member
- Using the Service Record Form, identify the Copay (stated as Patient Charge) and Surfee (stated as Additional Dispense) amounts

Description	Surfee (Identified as "Additional Dispense" on SRF)	Copay (Identified as "Patient Charge" on SRF)
Bifocal and Provider Supplied Frame		
Bifocal and Provider Supplied Frame		
Ultra Progressive	$ 60.00	$ 140.00
Polycarbonate Lens	$ 20.00	$ 35.00
Ultra Anti Reflective Coating	$ 15.00	$ 69.00
	$ 95.00	**$ 244.00**



The Steelworkers Health & Welfare Fund

Vision Care Service Record

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

DAVIS VISION EYECARE REFRAMED℠

SECTION I - PROVIDER/PATIENT SECTION

Member Name: _____

Member ID No.: _____

Patient Name: _____

Relationship: Member __ Spouse __ Child __

Provider's Name: _____

Provider's No.: _____

Authorization No.: USW _____

Authorization Date: _____

SECTION II - COVERAGE SECTION

Plan Level: Fashion

Copayments:
- Eye examination $0
- Frame and/or Spectacle lenses $0
- Contact Lenses:
  - Evaluation/fitting $0
  - Collection Lenses $0

Plan Description:
An eye examination (including dilation), contact lens evaluation/fitting, spectacle lenses and a frame or contact lenses in lieu of eyeglasses. Visually required contact lenses may be provided with prior approval. Members over age 19 are eligible annually for spectacle lenses with prior authorization of a prescription change.

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) ☐

D. Frame Provided:
Plan ☐ Patient's ☐ Provider's ☐

SECTION IV - ALLOWANCE SECTION

Frame	Contact Lens Material	Visually Required Contact Lens Material
$60	$75	Paid in full (prior approval required)

SECTION V - OPTIONS SECTION

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

Option	☑	Patient Charge	Additional Dispense
Designer Frame*	☐	$20	$10
Premier Frame*	☐	$40	$10
Ultraviolet Coating	☐	$15	$ 6
Scratch-Resistant Coating	☐	$20	$10
Tinted Lenses	☐	$15	N/A
Photochromic Lenses	☐	$20	$10
Blended Segments	☐	$20	$10
Intermediate Vision Lenses	☐	$30	$10
Standard Progressive Addition Multifocals	☐	$65	$30
Premium Progressive Addition Multifocals	☐	$105	$30
Ultra Progressive Addition Multifocals	☐	$140	$60
Polycarbonate Lenses**	☐	$35	$20
Standard ARC (anti-reflective coating)	☐	$40	$ 7
Premium ARC (anti-reflective coating)	☐	$55	$ 7
Ultra ARC (anti-reflective coating)	☐	$69	$15
Polarized Lenses	☐	$75	$25
High Index Lenses	☐	$60	$25
Plastic Photosensitive Lenses	☐	$70	$25

***For included Fashion level frames, a $10 additional dispense will apply.**
****No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/-6.00 or greater.**

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 for the Progressive Addition Lenses will not be refunded. **TN RESIDENTS:** Please see instruction 6 at right.

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 at right .

Authorized Signature _____

INSTRUCTIONS:
1. Participating provider must complete Sections I, III, V, and VIB.
2. Member 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.

Step 4 (CV)

Calculate Reimbursements

- Benefit Alerts and Payment Summary
- Enter Gross Reimbursements

Use the following formula to calculate Net Reimbursement:

Net = (Gross + Surfee) – Copay

To calculate profit (contractual reimbursement) use the following calculator:

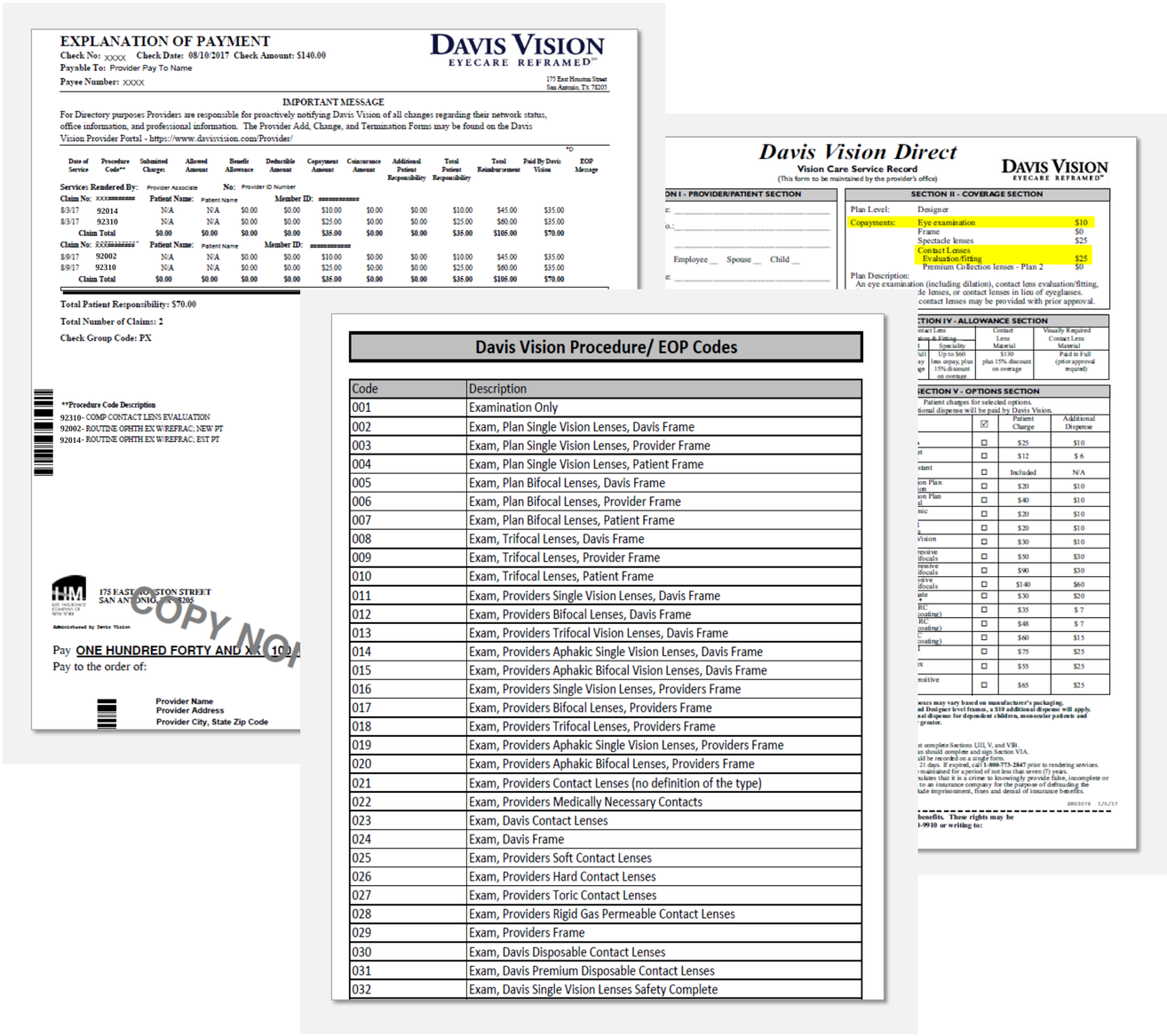
Profit = Gross + Surfee

Description	Gross	Surfee (Identified as "Additional Dispense" on SRF)	Copay	Net	Profit
Bifocal and Provider Supplied Frame	$ 12.50			$ 12.50	$ 12.50
Bifocal and Provider Supplied Frame	$ 33.25			$ 33.25	$ 33.25
Ultra Progressive		$ 60.00	$ 140.00	$ (80.00)	$ 60.00
Polycarbonate Lens		$ 20.00	$ 35.00	$ (15.00)	$ 20.00
Ultra Anti Reflective Coating		$ 15.00	$ 69.00	$ (54.00)	$ 15.00
	$ 45.75	**$ 95.00**	**$ 244.00**	**$ (103.25)**	**$ 140.75**

Step 1 (CVX)

Pull the following reference documents:

- Copy of EOP
- Copy of the Service Record Form (SRF)
- Davis Vision Procedure/ EOP Codes list
- Benefit Alert
- Payment Summary



EXPLANATION OF PAYMENT

Check No: XXXX Check Date: 08/10/2017 Check Amount: $140.00

Payable To: Provider Pay To Name

Payee Number: XXXX

DAVIS VISION EYECARE REFRAMED℠

175 East Houston Street San Antonio, TX 78205

IMPORTANT MESSAGE

For Directory purposes Providers are responsible for proactively notifying Davis Vision of all changes regarding their network status, office information, and professional information. The Provider Add, Change, and Termination Forms may be found on the Davis Vision Provider Portal - https://www.davisvision.com/Provider/

Date of Service	Procedure Code**	Submitted Charge	Allowed Amount	Benefit Allowance	Deductible Amount	Copayment Amount	Coinsurance Amount	Additional Patient Responsibility	Total Patient Responsibility	Total Reimbursement	Paid By Davis Vision	EOP Message
Services Rendered By: Provider Associate No: Provider ID Number												
Claim No: XXXXXXXXXX Patient Name: Patient Name Member ID: ##########												
8/3/17	92014	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$45.00	$35.00	
8/3/17	92310	N/A	N/A	$0.00	$0.00	$25.00	$0.00	$0.00	$25.00	$60.00	$35.00	
Claim Total		$0.00	$0.00	$0.00	$0.00	$35.00	$0.00	$0.00	$35.00	$105.00	$70.00	
Claim No: XXXXXXXXXX Patient Name: Patient Name Member ID: ##########												
8/9/17	92002	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$45.00	$35.00	
8/9/17	92310	N/A	N/A	$0.00	$0.00	$25.00	$0.00	$0.00	$25.00	$60.00	$35.00	
Claim Total		$0.00	$0.00	$0.00	$0.00	$35.00	$0.00	$0.00	$35.00	$105.00	$70.00	

Total Patient Responsibility: $70.00

Total Number of Claims: 2

Check Group Code: PX

**Procedure Code Description

92310- COMP CONTACT LENS EVALUATION

92002- ROUTINE OPHTH EX W/REFRAC; NEW PT

92014- ROUTINE OPHTH EX W/REFRAC; EST PT

175 EAST HOUSTON STREET SAN ANTONIO, TX 78205

Administered by Davis Vision

COPY NOT

Pay ONE HUNDRED FORTY AND XX/100

Pay to the order of:

Provider Name
Provider Address
Provider City, State Zip Code

Davis Vision Direct

Vision Care Service Record

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

DAVIS VISION EYECARE REFRAMED℠

SECTION I - PROVIDER/PATIENT SECTION

Employee __ Spouse __ Child __

SECTION II - COVERAGE SECTION

Plan Level: Designer

Copayments:

Eye examination	$10
Frame	$0
Spectacle lenses	$25
Contact Lenses Evaluation/fitting	$25
Premium Collection lenses - Plan 2	$0

Plan Description: An eye examination (including dilation), contact lens evaluation/fitting, ...le lenses, or contact lenses in lieu of eyeglasses. ...contact lenses may be provided with prior approval.

...TION IV - ALLOWANCE SECTION

...ntact Lens ...ion & Fitting	Contact Lens Material	Visually Required Contact Lens Material
Specialty		
Up to $60 ...less copay, plan ...15% discount on overage	$130 plus 15% discount on overage	Paid in Full (prior approval required)

...ECTION V - OPTIONS SECTION

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

	☑	Patient Charge	Additional Dispense
	☐	$25	$10
...t	☐	$12	$ 6
...stant	☐	Included	N/A
...ion Plan ...ion	☐	$20	$10
...ion Plan ...al	☐	$40	$10
...nic	☐	$20	$10
...l	☐	$20	$10
...Vision	☐	$30	$10
...nsive ...ifocals	☐	$50	$30
...nsive ...ifocals	☐	$90	$30
...nsive ...ifocals	☐	$140	$60
...ite	☐	$30	$20
...RC ...coating)	☐	$35	$ 7
...RC ...coating)	☐	$48	$ 7
...coating)	☐	$60	$15
...l	☐	$75	$25
...ix	☐	$55	$25
...nsitive	☐	$65	$25

...ices may vary based on manufacturer's packaging. ...ad Designer level frames, a $10 additional dispense will apply. ...dispense for dependent children, monocular patients and ...r greater.

...t complete Sections I,II, V, and VIII. ...n should complete and sign Section VIA. ...uld be recorded on a single form. ...21 days. If expired, call 1-800-773-2847 prior to rendering services. ...maintained for a period of not less than seven (7) years. ...nalties that it is a crime to knowingly provide false, incomplete or ...to an insurance company for the purpose of defrauding the ...hade imprisonment, fines and denial of insurance benefits.

...benefits. These rights may be ...-9910 or writing to:

Davis Vision Procedure/ EOP Codes

Code	Description
001	Examination Only
002	Exam, Plan Single Vision Lenses, Davis Frame
003	Exam, Plan Single Vision Lenses, Provider Frame
004	Exam, Plan Single Vision Lenses, Patient Frame
005	Exam, Plan Bifocal Lenses, Davis Frame
006	Exam, Plan Bifocal Lenses, Provider Frame
007	Exam, Plan Bifocal Lenses, Patient Frame
008	Exam, Trifocal Lenses, Davis Frame
009	Exam, Trifocal Lenses, Provider Frame
010	Exam, Trifocal Lenses, Patient Frame
011	Exam, Providers Single Vision Lenses, Davis Frame
012	Exam, Providers Bifocal Lenses, Davis Frame
013	Exam, Providers Trifocal Vision Lenses, Davis Frame
014	Exam, Providers Aphakic Single Vision Lenses, Davis Frame
015	Exam, Providers Aphakic Bifocal Vision Lenses, Davis Frame
016	Exam, Providers Single Vision Lenses, Providers Frame
017	Exam, Providers Bifocal Lenses, Providers Frame
018	Exam, Providers Trifocal Lenses, Providers Frame
019	Exam, Providers Aphakic Single Vision Lenses, Providers Frame
020	Exam, Providers Aphakic Bifocal Lenses, Providers Frame
021	Exam, Providers Contact Lenses (no definition of the type)
022	Exam, Providers Medically Necessary Contacts
023	Exam, Davis Contact Lenses
024	Exam, Davis Frame
025	Exam, Providers Soft Contact Lenses
026	Exam, Providers Hard Contact Lenses
027	Exam, Providers Toric Contact Lenses
028	Exam, Providers Rigid Gas Permeable Contact Lenses
029	Exam, Providers Frame
030	Exam, Davis Disposable Contact Lenses
031	Exam, Davis Premium Disposable Contact Lenses
032	Exam, Davis Single Vision Lenses Safety Complete

Step 2 (CVX)

Identify Details of the Claim and Verify Reimbursements

- Identify the Procedure Code Column on the EOP
- Use the Davis Vision Procedure/ EOP Codes list to identify the different parts of the claim. With CVX, the Claim is already broken down to a specific level
- Using the Service Record Form, highlight all options chosen by member and verify the Additional Patient Responsibility (stated as Patient Charge under Section V), Copays (identified under Section II) and Total Reimbursement (stated as Additional Dispense under Section V) amounts

Date of Service	Procedure Code**	Submitted Charges	Allowed Amount	Benefit Allowance	Deductible Amount	Copayment Amount	Coinsurance Amount	Additional Patient Responsibility	Total Patient Responsibility	Total Reimbursement	Paid By Davis Vision	EOP Message
Services Rendered By:	Provider Associate	**No:**	Provider ID Number									
Claim No:	XXX########	**Patient Name:**	Name of Patient		**Member ID:**	ID Number						
8/9/17	92002	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$46.35	$36.35	
8/9/17	V2020	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$22.88	$22.88	
8/9/17	V2781	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.00	$15.00	
8/9/17	V2781	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.00	$15.00	
8/9/17	V2203	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$6.44	($3.56)	
8/9/17	V2203	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$6.44	($3.56)	
	Claim Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$30.00**	**$0.00**	**$0.00**	**$30.00**	**$112.11**	**$82.11**	

Total Patient Responsibility: $30.00 **Total Reimbursement: $112.11** **Check Amount: $82.11**

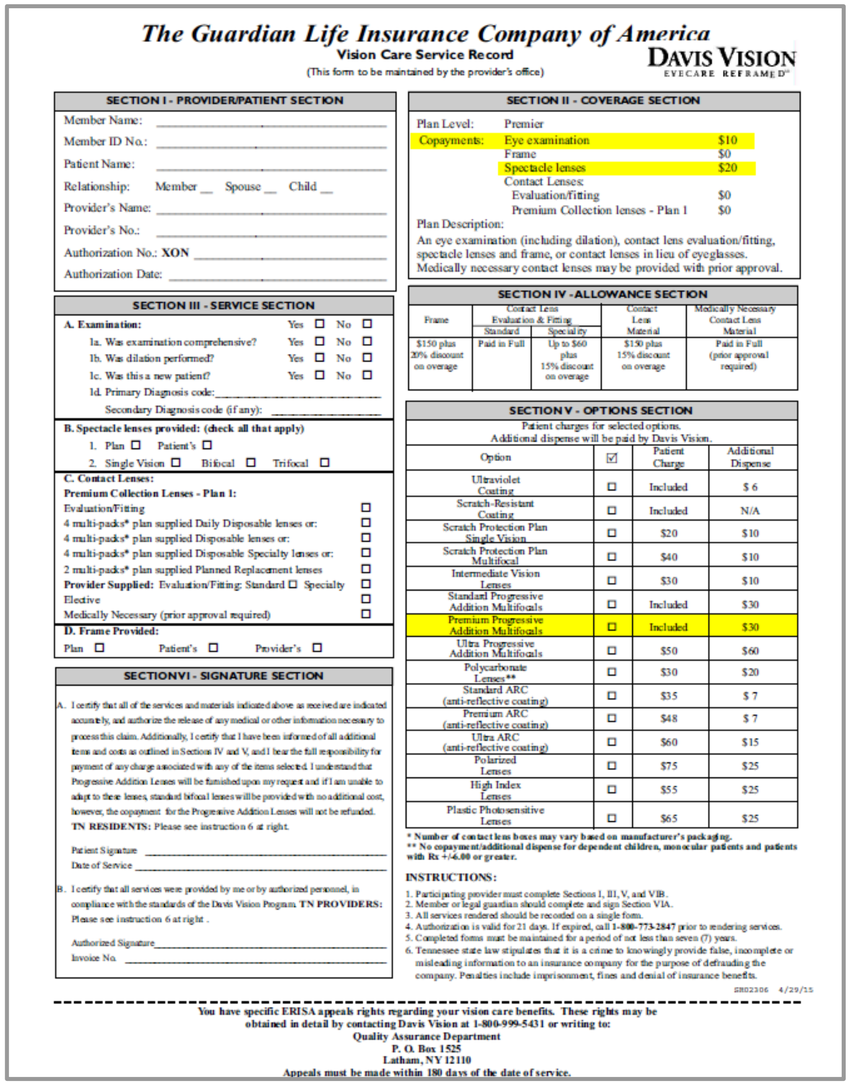
Total Number of Claims: 1

Check Group Code: PX

Balance Forward: $0.00

Current Activity: $82.11

Ending Balance: $82.11



The Guardian Life Insurance Company of America

Vision Care Service Record

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

DAVIS VISION EYECARE REFRAMED℠

SECTION I - PROVIDER/PATIENT SECTION

Member Name: _____

Member ID No.: _____

Patient Name: _____

Relationship: Member __ Spouse __ Child __

Provider's Name: _____

Provider's No.: _____

Authorization No.: XON _____

Authorization Date: _____

SECTION II - COVERAGE SECTION

Plan Level: Premier

Copayments:		
	Eye examination	$10
	Frame	$0
	Spectacle lenses	$20
	Contact Lenses:	
	Evaluation/fitting	$0
	Premium Collection lenses - Plan 1	$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.

SECTION III - SERVICE SECTION

A. Examination:

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-packs* plan supplied Daily Disposable lenses or: ☐

4 multi-packs* plan supplied Disposable lenses or: ☐

4 multi-packs* plan supplied Disposable Specialty lenses or: ☐

2 multi-packs* plan supplied Planned Replacement lenses ☐

Provider Supplied: Evaluation/Fitting: Standard ☐ Specialty ☐

Elective ☐

Medically Necessary (prior approval required) ☐

D. Frame Provided:

Plan ☐ Patient's ☐ Provider's ☐

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	Paid in Full (prior approval required)

SECTION V - OPTIONS SECTION

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

Option	☑	Patient Charge	Additional Dispense
Ultraviolet Coating	☐	Included	$ 6
Scratch-Resistant Coating	☐	Included	N/A
Scratch Protection Plan Single Vision	☐	$20	$10
Scratch Protection Plan Multifocal	☐	$40	$10
Intermediate Vision Lenses	☐	$30	$10
Standard Progressive Addition Multifocals	☐	Included	$30
Premium Progressive Addition Multifocals	☐	Included	$30
Ultra Progressive Addition Multifocals	☐	$50	$60
Polycarbonate Lenses**	☐	$30	$20
Standard ARC (anti-reflective coating)	☐	$35	$ 7
Premium ARC (anti-reflective coating)	☐	$48	$ 7
Ultra ARC (anti-reflective coating)	☐	$60	$15
Polarized Lenses	☐	$75	$25
High Index Lenses	☐	$55	$25
Plastic Photosensitive Lenses	☐	$65	$25

* Number of contact lens boxes may vary based on manufacturer's packaging.
** No copayment/additional dispense for dependent children, monocular patients and patients with Rx +/-6.00 or greater.

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 for the Progressive Addition Lenses will not be refunded. **TN RESIDENTS:** Please see instruction 6 at right.

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 at right .

Authorized Signature_____

Invoice No. _____

INSTRUCTIONS:

1. Participating provider must complete Sections I, III, V, and VI/B.
2. Member or legal guardian should complete and sign Section VI/A.
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 company. Penalties include imprisonment, fines and denial of insurance benefits.

SH02306 4/29/15

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.

Step 3 (CVX)

Calculate Reimbursements

Use the following formula to calculate Davis Vision Reimbursement:

Paid by Davis Vision = Total Reimbursement – Patient Responsibility

Check Amount = All the totals of the Paid by Davis Vision column

Total Reimbursement = Profit

Date of Service	Procedure Code**	Submitted Charges	Allowed Amount	Benefit Allowance	Deductible Amount	Copayment Amount	Coinsurance Amount	Additional Patient Responsibility	Total Patient Responsibility	Total Reimbursement	Paid By Davis Vision	EOP Message
Services Rendered By: Provider Associate		**No:** Provider ID Number										
Claim No: XXX########		**Patient Name:** Name of Patient				**Member ID:** ID Number						
8/9/17	**92002**	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$46.35	$36.35	
8/9/17	V2020	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$22.88	$22.88	
8/9/17	V2781	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.00	$15.00	
8/9/17	V2781	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$15.00	$15.00	
8/9/17	V2203	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$6.44	($3.56)	
8/9/17	V2203	N/A	N/A	$0.00	$0.00	$10.00	$0.00	$0.00	$10.00	$6.44	($3.56)	
Claim Total		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$30.00**	**$0.00**	**$0.00**	**$30.00**	**$112.11**	**$82.11**	

Total Patient Responsibility: $30.00

Total Reimbursement: $112.11

Check Amount: $82.11

Total Number of Claims: 1

Check Group Code: PX

Balance Forward: $0.00

Current Activity: $82.11

Ending Balance: $82.11

Step 4 (CVX)

Calculate Reimbursements

- Benefit Alerts and/ Payment Summary
- Use the Davis Vision Procedure/ EOP Codes list or the last page of the EOP to identify the different parts of the claim
- Lens options are broken down in 2 parts; one line for each lens

Use the following formula to calculate the Paid by Davis Vision column:

Paid by Davis = Total Reimbursement – Total Patient Responsibility

To calculate profit (contractual reimbursement) use the following calculator:

Profit = Total Reimbursement

Procedure Code	Description	Total Reimbursement	Patient Responsibility (Copays + Additional Patient Responsibility)	Paid by Davis Vision
92002	Exam	$ 46.35	$ 10.00	$ 36.35
V2020	Davis Vision Collection Frame	$ 22.88	$ -	$ 22.88
V2203	Bifocal	$ 6.44	$ 10.00	$ (3.56)
V2203	Bifocal	$ 6.44	$ 10.00	$ (3.56)
V2781	Premium Progressive	$ 15.00	$ -	$ 15.00
V2781	Premium Progressive	$ 15.00	$ -	$ 15.00
TOTAL		**$ 112.11**	**$ 30.00**	**$ 82.11**

CONTACT NUMBERS

Provider Services

1-800-584-3140

Monday – Friday: 8AM – 6PM EST

Excel Advantage

1-800-933-9375

Go to www.davisvision.com

Order Entry

1-800-888-4321

Go to www.davisvision.com

Utilization Review

1-800-584-2329

Monday – Friday: 8AM – 6PM EST

Quality Assurance

1-888-343-3470

Go to www.davisvision.com

Website Assistance

1-800-943-5738

APPENDIX