DAVIS VISION
THE EYECARE ADVANTAGE
www.davisvision.com

Blue Cross Blue Shield of Texas

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

SECTION I - PROVIDER/PATIENT SECTION

Member Name: _____

Member ID No.: _____

Patient Name: _____

Relationship: Member __ Spouse __ Child __

Provider's Name: _____

Provider's No.: _____

SECTION II - COVERAGE SECTION

Plan Level:	Affinity Discount	
Copayments:	Eye examination	$15% of U & C
	Frame	Discount only see below
	Spectacle lenses	Discount only see below
	Contact Lenses:	Discount only see below

Plan Description: Eye examination (including dilation as professionally indicated), spectacle lenses and a frame or contact lenses (in lieu of eyeglasses).

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)*

		Member Pays:
Single Vision	☐	$35.00
Bifocal	☐	$55.00
Trifocal	☐	$65.00
Lenticular	☐	$110.00

C. Contact Lenses:

		Member Pays:
Contact Lens Examination	☐	15% off U & C
Conventional	☐	20% off U & C
Disposable/planned replacement	☐	10% off U & C

D. Frame Provided*:

		Member Pays
Priced up to $70 retail	☐	$40
Priced above $70 retail	☐	$40 plus 10% off the amount over $70.00

SECTION IV - OPTIONS SECTION*

Patient charges for selected options.
(in addition to lens price)

Option	☑	Patient Charge
Standard Progressive Lenses	☐	$60.00
Premium Progressive Lenses	☐	$110.00
Blended Invisible Bifocals	☐	$20.00
High Index	☐	$55.00
Polarized Lenses	☐	$75.00
Glass Lenses	☐	$18.00
Polycarbonate Lenses	☐	$30.00
Scratch-Resistant Coating	☐	$15.00
ARC (anti-reflective coating)	☐	$45.00
Ultraviolet Coating	☐	$15.00
Solid Tint	☐	$10.00
Gradient Tint	☐	$12.00
Photochromic Lenses	☐	$35.00
Plastic Photosensitive Lenses	☐	$65.00
Intermediate Vision Lenses	☐	$30.00

*Special lens designs, materials, powers and frames may require additional cost. Prices represent maximum patient charges for the items listed.

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 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, VI, 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 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.

SR01220 12/26/06

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.

BlueCross BlueShield

BlueChoice® Solutions

www.bcbstx.com

Subscriber: FirstName M. LastName

Identification No.: ZGP111223333 Group No.: 92042

Coverage Date: 01-01-04 BC Plan: 400 BS Plan: 900

Family

Network No.: PSNOA

Office Copay	50%
Emergency Copay	50%
RX Generic Copay	$5
RX Brand Copay	$5$10

PPO

BlueCross BlueShield

BlueChoice®

www.bcbstx.com

Name: FirstName M. LastName

Identification No.: ZG0123456789 Group No.: 0054946

Coverage Date: 01-01-00 BC Plan: 400

Primary Care Physician: Network No.: PTXOA

PCP Name

Telephone No.: PCP PHONE

Office Copay	$15
Emergency Copay	$50
RX Generic Copay	$5
RX Brand Copay	$5$10

BlueCross BlueShield

UT SELECT

Subscriber: FirstName M. LastName

Identification No.: UTS123456789 Group No.: 071778

Coverage Date: 09-01-03 BC Plan: 400 BS Plan: 900

Contract Code: 101

Network No.: PTXOA

Family Care Copay	$25
Specialist Copay	$30
Emergency Copay	$100

PPO

Rx Annual Deductible/Person $50

Group No. UTSYSRX Rx Retail Copay $10/$25/$40

BlueCross BlueShield

www.bcbstx.com

Subscriber: FirstName M. LastName

Identification No.: ZGB123456789 Group No.: 0081511

Coverage Date: 01-01-03 BC Plan: 400 BS Plan: 900

Family

RX Generic Copay	$10
RX Brand Copay	$20/$30

BlueCross BlueShield

Select

www.bcbstx.com

Subscriber: FirstName M. LastName

Identification No.: ZG0123456789 Group No.: 0054946

Coverage Date: 01-01-00 BC Plan: 400 BS Plan: 900

Network No.: PTXOA

Office Copay	$15
Emergency Copay	$50
RX Generic Copay	$5
RX Brand Copay	$5/$10

PPO

TDI

BlueCross BlueShield

www.bcbstx.com

Subscriber: FirstName M. LastName

Identification No.: ZGP111223333 Group No.: H11234

Coverage Date: 01-01-05 BC Plan: 400 BS Plan: 900

Family

Network No.: PTXOA

RX Generic Copay	$10
RX Brand Copay	$25/$50

DENTF

PPO

BlueEdge