



Affinity 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.: _____

Authorization No.: _____

Authorization Date: _____

SECTION II - COVERAGE SECTION

Plan Level: Affinity

Copayments:

Eye examination 15% off providers U&C

Refraction Only \$20.00
(when exam is covered by Medicare)

Contact lens examination 15% off providers U&C

Frame Discount only see section III

Spectacle lenses Discount only see section III

Contact Lenses: Discount only see section III

Plan Description: A discounted eye examination, and a discount towards the cost of spectacle lenses and a frame, or contact lenses.

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)*

		<u>Member Pays:</u>
Single Vision	<input type="checkbox"/>	\$35.00
Bifocal	<input type="checkbox"/>	\$55.00
Trifocal	<input type="checkbox"/>	\$65.00
Lenticular	<input type="checkbox"/>	\$110.00

C. Contact Lenses: Member Pays:

Conventional ☐ 20% off U & C

Disposable/planned replacement ☐ 10% off U & C

D. Frame Provided*:

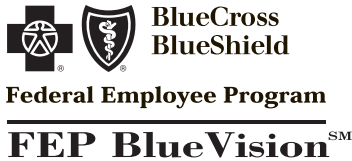
	<u>Member Pays:</u>
Priced up to \$70 retail <input type="checkbox"/>	\$40
Priced above \$70 retail <input type="checkbox"/>	\$40 plus 10% off the amount over \$70.00

SECTION IV - OPTIONS SECTION*

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

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

*Special lens designs, materials, powers and frames may require additional cost.
Member cost may vary dependent upon retailer selected.



Premier 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.: _____

Authorization No.: **FEP** _____

Authorization Date: _____

SECTION II - COVERAGE SECTION

Plan Level: Premier

Copayments: Eye examination \$ 0.00
Frame and/or Spectacle lenses \$ 0.00
Contact Lens Formulary \$ 0.00

Plan Description: An eye examination (including dilation), frames and spectacle lenses or contact lenses in lieu of eyeglasses.
Medically necessary contact lenses may be provided with prior approval.

SECTION IV - ALLOWANCE SECTION

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

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: Plan Supplied:Formulary ☐**Provider Supplied:**Elective ☐Medically Necessary ☐**D. Frame Provided:**Plan ☐ Patient's ☐ Provider's ☐**SECTION V - OPTIONS SECTION**

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

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

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