

# Nova Healthcare Administrators, Inc.

**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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>
Provider's Name:	_____
Provider's No.:	_____
Authorization No.:	<b>XGY</b> _____
Authorization Date:	_____

SECTION II - COVERAGE SECTION											
Plan Level:	Hybrid Affinity										
Copayments:	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Eye examination</td> <td style="width: 50%;">\$10</td> </tr> <tr> <td>Evaluation/fitting</td> <td>15% discount</td> </tr> <tr> <td>Frame</td> <td>Discount only see section III</td> </tr> <tr> <td>Spectacle lenses</td> <td>Discount only see section III</td> </tr> <tr> <td>Contact Lenses:</td> <td>Discount only see section III</td> </tr> </table>	Eye examination	\$10	Evaluation/fitting	15% discount	Frame	Discount only see section III	Spectacle lenses	Discount only see section III	Contact Lenses:	Discount only see section III
Eye examination	\$10										
Evaluation/fitting	15% discount										
Frame	Discount only see section III										
Spectacle lenses	Discount only see section III										
Contact Lenses:	Discount only see section III										
Plan Description:	Eye examination (including dilation), discount towards spectacle lenses and a frame or contact lenses in lieu of eyeglasses.										

SECTION III - SERVICE SECTION	
<b>A. Examination:</b>	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>B. Spectacle Lenses Provided*:</b>	Member Pays:
Single Vision <input type="checkbox"/>	\$35
Bifocal <input type="checkbox"/>	\$55
Trifocal <input type="checkbox"/>	\$65
Lenticular <input type="checkbox"/>	\$110
<b>C. Contact Lenses:</b>	Member Pays:
Contact Lens Examination <input type="checkbox"/>	15% off U & C
Conventional <input type="checkbox"/>	20% off U & C
Disposable/planned replacement <input type="checkbox"/>	10% off U & C
<b>D. Frame Provided*:</b>	Member Pays
Priced up to \$70 retail <input type="checkbox"/>	\$40
Priced above \$70 retail <input type="checkbox"/>	\$40 plus 10% off the amount over \$70

SECTION IV - OPTIONS SECTION*		
Patient charges for selected options. (in addition to lens price)		
Option	<input type="checkbox"/>	Patient Charge
Standard Progressive Lenses	<input type="checkbox"/>	\$75
Premium Progressive Lenses	<input type="checkbox"/>	\$125
Blended Invisible Bifocals	<input type="checkbox"/>	\$20
High Index	<input type="checkbox"/>	\$55
Polarized Lenses	<input type="checkbox"/>	\$75
Glass Lenses	<input type="checkbox"/>	\$18
Polycarbonate Lenses	<input type="checkbox"/>	\$30
Scratch-Resistant Coating	<input type="checkbox"/>	\$20
Standard ARC (anti-reflective coating)	<input type="checkbox"/>	\$45
Ultraviolet Coating	<input type="checkbox"/>	\$15
Solid Tint	<input type="checkbox"/>	\$10
Gradient Tint	<input type="checkbox"/>	\$12
Photochromic Lenses	<input type="checkbox"/>	\$35
Plastic Photosensitive Lenses	<input type="checkbox"/>	\$65
Intermediate Vision Lenses	<input type="checkbox"/>	\$30

SECTION VI - SIGNATURE SECTION	
<p>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. <b>TN RESIDENTS:</b> Please see instruction 6 at right.</p>	
Patient Signature _____	_____
Date of Service _____	_____
<p>B. I certify that all services were provided by me or by authorized personnel, in compliance with the standards of the Davis Vision Program. <b>TN PROVIDERS:</b> Please see instruction 6 at right .</p>	
Authorized Signature _____	_____
Invoice No. _____	_____

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

**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.
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 1-800-553-2944 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.