The New York State Vision Plan

Vision Care Service Record

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

DavisVision™

SECTION I - PROVIDER/PATIENT SECTION

Member Name: _____

Member ID No.: _____

Patient Name: _____

Relationship: Member __ Spouse __ Child __

Provider's Name: _____

Provider's No.: _____

Authorization No.: **XII** _____

Authorization Date: _____

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-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 ☐

D. Frame Provided:

Plan ☐ Patient's ☐ Provider's ☐

SECTION IV - 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. **SERVICES CAN NOT BE SPLIT. ALL SERVICES MUST BE RECEIVED AT THE SAME TIME.**

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. _____

SECTION II - COVERAGE SECTION

Plan Level: Fashion

Copayments:		
	Eye examination	$10
	Frame* and/or Spectacle lenses	$0
	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 a frame or contact lenses in lieu of eyeglasses.

Please Note:Services can not be split. All services must be received at the same time.

SECTION IV - ALLOWANCE SECTION

Frame	Contact Lens Material
$80	$105

SECTION V - OPTIONS SECTION

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

Option	☑	Patient Charge	Additional Dispense
Polycarbonate Lenses**	☐	$0	N/A

*** Number of contact lens boxes may vary based on manufacturer's packaging.**
****This coverage is only available for dependent children, monocular patients and patients with Rx +/-6.00 or greater.**

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.

SEHP SR02117 2/17/21

You have specific ERISA appeals rights regarding your vision care benefits. These rights may be obtained in detail by contacting Davis Vision at 1-888-588-4823 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.