Healthfirst Health Plan, Inc.

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.: _____

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:

Provider Supplied: Evaluation/Fitting: Standard ☐ Specialty ☐

Elective ☐

Visually Required (prior approval required) ☐

D. Frame Provided:

Plan ☐ Patient's ☐ Provider's ☐

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. _____

SECTION II - COVERAGE SECTION

Plan Level: Designer Prefix: **HFQ, HFH**

Copayments:		
	Eye examination	$0
	Frame and/or Spectacle lenses	$0
	Contact Lenses	$0

Plan Description:

An eye examination (including dilation), contact lens evaluation/fitting, spectacle lenses and frame, or provider supplied contact lenses in lieu of eyeglasses. The contact lens evaluation/fitting is NOT a separate component of the benefit. It must be received in conjunction with a dispense of contact lenses. Visually Required contact lenses may be provided with prior approval.

SECTION IV - ALLOWANCE SECTION

Frame*	Contact Lens Evaluation & Fitting		Contact Lens Material*	Visually Required Contact Lens Material
	Standard	Specialty		
$150	Paid in Full	Up to $60 plus 15% discount on overage	$125	Paid in Full (prior approval required)

*Member cannot select any non plan frame or contact lens beyond $150/$125

SECTION V - OPTIONS SECTION

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

Option	☑	Patient Charge	Additional Dispense
Premier Frame**	☐	$30	$10
Ultraviolet Coating	☐	$17	$ 6
Scratch-Resistant Coating	☐	Included	N/A
Scratch Protection Plan Single Vision	☐	$20	$10
Scratch Protection Plan Multifocal	☐	$40	$10
Tinted Lenses	☐	$5	N/A
Photochromic Lenses	☐	$5	$10
Blended Segments	☐	$25	$10
Intermediate Vision Lenses	☐	$35	$10
Standard Progressive Addition Multifocals	☐	$55	$30
Premium Progressive Addition Multifocals	☐	$95	$30
Ultra Progressive Addition Multifocals	☐	$140	$55
Polycarbonate Lenses***	☐	$35	$20
Standard ARC (anti-reflective coating)	☐	$40	$ 7
Premium ARC (anti-reflective coating)	☐	$53	$ 7
Ultra ARC (anti-reflective coating)	☐	$65	$10
Polarized Lenses	☐	$80	$25
High Index Lenses	☐	$60	$25
Plastic Photosensitive Lenses	☐	$70	$25

****For included Fashion or Designer 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.**

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.

SR01724 2/10/22

You have specific ERISA appeals rights regarding your vision care benefits. These rights may be obtained in detail by contacting Vision member services at 1-866-463-6743 or writing to:
Appeals & Grievance Department - P. O. Box 5166 - New York, NY 10274
Appeals must be made within 180 days of the date of service.