HealthFirst PHSP, Inc.
CHP/FHP/Medicaid
Vision Care Service Record
(This form to be maintained by the provider's office)

DAVIS VISION
EYECARE REFRAMED℠

SECTION I - PROVIDER/PATIENT SECTION

Member Name: _____

Member ID No.: _____

Provider's Name: _____

Provider's No.: _____

Authorization No.: _____

Authorization Date: _____

SECTION III - SERVICE SECTION

A. Examination: Routine Yes ☐ No ☐

VDT Testing 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:

Medically Necessary (prior approval required) ☐

D. Frame Provided:

Plan ☐ Patient's ☐ Provider's ☐

E. Occupational (VDT)eyewear:

Spectacle lenses provided:

Single Vision ☐ Bifocal ☐ Trifocal ☐

Frame Provided:

Plan ☐ Patient'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 (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. _____

SECTION II - COVERAGE SECTION

Plan Level:	Fashion	Prefix: HFA, HFB, HFC
Copayments:	Eye examination	$0
	Frame and/or Spectacle lenses	$0
	Contact Lenses:	
	Medically Necessary	$0

Plan Description:

HFA: Eye examination (including dilation), and spectacle lenses and frame. Medically necessary contact lenses are covered in full with prior approval.

HFB: Eye examination (including dilation), and spectacle lenses and frame. Medically necessary contact lenses are covered in full with prior approval. Diabetic members are entitled to an annual eye exam and eyeglasses if there is a change in correction of .5 diopters or greater.

HFC: Eye examination (including dilation), and spectacle lenses and frame. Medically necessary contact lenses are covered in full with prior approval. Occupational (VDT) eyeglasses may be provided in conjunction to the routine vision benefit (VDT Questionnaire is required). More frequent services may be available for members under age 21 when professionally indicated (prior approval is required). Diabetic members are entitled to an annual eye exam and eyeglasses if there is a change in correction of .5 diopters or greater.

SECTION IV - ALLOWANCE SECTION

Medically Necessary Contact Lens Material	Paid in Full (prior approval required)

SECTION V - OPTIONS SECTION

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

Option	☑	Patient Charge	Additional Dispense
Ultraviolet Coating	☐	Included	$ 6
Blended Segments	☐	Included	$10
Tinted Lenses	☐	Included	N/A
Polycarbonate Lenses (prior approval required)	☐	Included	$20

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 to expire at the end of the month. 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.

SR00592 7/10/18

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.

Member Questionnaire

This is your VDT Questionnaire Form for obtaining a VDT vision analysis and, if necessary special eyeglasses.

If you feel you may have a need for job-related eyeglasses and, therefore, would like an VDT vision analysis, complete the following questionnaire. If VDT eyeglasses are advised, they will be provided in addition to any regular eyeglasses obtained with your authorization.

1. Do you have any problems with your eyes during the work day? Yes ☐ No ☐

2. Do problems with your eyes reduce your efficiency or the accuracy of your work? Yes ☐ No ☐

   a. If yes, when is your work most affected? AM ☐ PM ☐ Mid-day ☐ Late in day ☐

3. Do you think that a pair of occupational eyeglasses might:

   make you more comfortable at work ☐ improve your work ☐ both ☐

4. Do you currently use eyeglasses at work? Yes ☐ No ☐

   a. If yes, please indicate the type: Single vision ☐ Bifocal ☐ Trifocal ☐

   b. Indicate when worn: All day ☐ Desk work ☐ Typing ☐ VDT work ☐ Distance seeing ☐

5. What are the visual demands on your job? (Indicate the percentage of your work spent on these tasks)

   Typing (word processing): ____ Data entry on computer terminal: ____ Accessing data from terminal: ____

   Computer programming: ____ General desk work: ____ Other office duties: ____

6. If you work at a VDT screen, answer the following questions:

   a. Are the characters clear on the screen? Yes ☐ No ☐

   b. Do you have bothersome reflections from the screen? Yes ☐ No ☐

   c. Can you tilt your screen? Yes ☐ No ☐

   d. Do you think the screen height is: okay ☐ too high ☐ too low ☐

Name: _____ Identification Number: _____

Job Title: _____ Signature: _____

Provider Questionnaire

1. Have you conducted a VDT vision analysis for this patient? Yes ☐ No ☐

2. Are you providing VDT eyeglasses? Yes ☐ No ☐ (if yes, please continue)

3. What type of VDT lenses? Single vision ☐ Bifocal, high seg. ☐ Bifocal, normal seg. ☐

   Trifocal, 7 mm inter. zone ☐ Trifocal, 14 mm inter. zone ☐

4. In what way(s) do the VDT eyeglasses differ from the patient's regular eyeglasses? (NOTE: At least one difference must be indicated)

   RX ☐ Seg. height ☐ Lens type ☐ Tint ☐

Provider Number: _____ Signature: _____ Date: _____