

# Fidelis CareHARP/ Fidelis Care - Medicaid/Child Health Plus

## 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 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:

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: Fashion Prefix: FD1, FD2, FD6, FD7, FD9

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

#### Plan Description:

**FD1, FD6 & FD9:** Eye examination(including dilation) spectacle lenses and a frame or Visually Required contact lenses in lieu of eyeglasses. Patients may elect (with prior approval) to receive two complete pair of eyeglasses (for both distance and reading) rather than bifocal lenses. Both pair of glasses must be ordered and dispensed at the same time.

**FD2, FD7:** Eye examination(including dilation) spectacle lenses and a frame or Visually Required contact lenses in lieu of eyeglasses.

#### All prefixes:

Diabetics may receive an annual eye examination (including dilation) spectacle lenses and a frame (must have RX change) with prior approval.

### SECTION IV - ALLOWANCE SECTION

Visually Required  
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	<input checked="" type="checkbox"/>	Patient Charge	Additional Dispense
Polycarbonate Lenses*	<input type="checkbox"/>	Included	\$10
Tinted Lenses	<input type="checkbox"/>	Included	N/A
Oversized Lenses	<input type="checkbox"/>	Included	N/A

\* No 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 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.

SR00725 2/18/20

You have specific ERISA appeals rights regarding your vision care benefits. These rights may be obtained in detail by contacting Davis Vision at 1-800-999-5431 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.