Faneuil, Inc.

Vision Care Service Record (This form to be maintained by the provider's office)



Ic. Was this a new patient? Yes No 1d. Primary Diagnosis code:			SECTION II - COVERAGE SECTION			
Employee ID No.:	Employee Name:	Plan Level: De	esigner			
Patient Name:						
Relationship: EmployeeSpouseChild Provider's Name:		Spectacle lenses \$10				
Relationship: EmployeeSpouse Spouse Provider's Name:						
Provider's Name:		Premium Collection lenses - Plan 1 \$0				
Authorization No.: YDJ	Provider's Name:					
Authorization No.: YDJ	Provider's No.:	Plan Description:				
Authorization Date: Join Contact Lens Visually Required Contact Lens SECTION III - SERVICE SECTION Frame Contact Lens Contact Lens Authorization: Yes No Secondary Diagnosis code: Secondary Diagnosis code: Secondary Diagnosis code: Secondary Diagnosis code: Paid in full 10. Was this a new patient? Yes No Secondary Diagnosis code: Paid in full 10. Primary Diagnosis code: Secondary Diagnosis code: Secondary Diagnosis code: Patient charges for selected options. B. Spectacle lenses provided: Check III that apply) Patient charges for selected options. Additional dispense will be paid by Davis Vision. 1. Plan Patient's Option Patient Additional 2. Single Vision Bifocal Trifocal Premier Scottact Lenses: Premium Collection Lenses - Plan 1: Ultraviolet Scratch-Resistant Included N/A 4 multi-packs* plan supplied Disposable lenses or: Gorating Scratch-Resistant Included N/A 2 multi-packs* plan supplied Disposable lenses or: Single Vision Scratch Protection Plan Standard Progressive Standard Progressive Standard Progressive <td></td> <td colspan="4">contact lenses in lieu of eyeglasses. Visually Required contact lenses may</td>		contact lenses in lieu of eyeglasses. Visually Required contact lenses may				
SECTION III - SERVICE SECTION A. Examination: Yes No 1a. Was examination comprehensive? Yes No Material Contact Lens Contact Lens Contact Lens 1b. Was dilation performed? Yes No Iside Transmitter Status Status Paid in full 1c. Was this a new patient? Yes No Iside Transmitter Yes No 1d. Primary Diagnosis code:						
A. Examination: Yes No Material Contact Lens Material A. Examination: Yes No Standard Standard Standard Paid in full 1a. Was examination comprehensive? Yes No Standard Standard Paid in full 1b. Was dilation performed? Yes No Standard Standard Paid in full 1c. Was this a new patient? Yes No Standard Standard Paid in full 1c. Was this a new patient? Yes No Standard Standard Paid in full 1d. Primary Diagnosis code:						
1a. Was examination comprehensive? Yes No \$120 plus 20% \$130 plus 15% Paid in full 1b. Was dilation performed? Yes No \$120 plus 20% \$130 plus 15% Paid in full 1b. Was dilation performed? Yes No \$120 plus 20% \$130 plus 15% Paid in full 1b. Was dilation performed? Yes No \$10 plus 15% \$10 plus 15% \$10 plus 15% 1c. Was this a new patient? Yes No \$10 plus 20% \$130 plus 15% \$10 plus 15% 1d. Primary Diagnosis code:		Frame				
1b. Was dilation performed? Yes No Inclusted Inclusted (prior approval required) 1c. Was this a new patient? Yes No Inclusted (prior approval required) 1d. Primary Diagnosis code: Secondary Diagnosis code (if any): Patient charges for selected options. Patient charges for selected options. B. Spectacle lenses provided: (check all that apply) Inclusted Patient charges for selected options. Additional dispense will be paid by Davis Vision. 1. Plan Patient's Patient charges Patient charges Patient charge Dispense C. Contact Lenses: Premiur Option ✓ Patient Additional Premiur Collection Lenses - Plan 1: Ultraviolet S25 \$10 Evaluation/Fitting Included N/A 4 multi-packs* plan supplied Daily Disposable lenses or: Scratch-Resistant Included N/A 2 multi-packs* plan supplied Planned Replacement lenses Scratch Protection Plan \$40 \$10 Provider Supplied: Evaluation/Fitting: Standard Specialty Standard Progressive \$50 \$30 Visually Required (prior approval required) Included \$40 \$10 <		±	-			
Id. Primary Diagnosis code:	1b. Was dilation performed? Yes □ No	discount off overage	discount off overa	ige (prior	approval required)	
Secondary Diagnosis code (if any):	1					
1. Plan Patient's Additional 2. Single Vision Bifocal Trifocal Image: Charge Dispense C. Contact Lenses: Premier Image: Charge S25 \$10 Premium Collection Lenses - Plan 1: Image: Charge Vilraviolet Image: Charge \$12 \$6 4 multi-packs* plan supplied Daily Disposable lenses or: Image: Charge Scratch-Resistant Image: Charge N/A 4 multi-packs* plan supplied Disposable lenses or: Image: Charge Scratch-Resistant Image: Charge N/A 2 multi-packs* plan supplied Disposable Specialty lenses or: Image: Charge Scratch Protection Plan \$20 \$10 2 multi-packs* plan supplied Planned Replacement lenses Image: Charge Scratch Protection Plan \$40 \$10 2 multi-packs* plan supplied: Evaluation/Fitting: Standard I Specialty Image: Charge Standard Progressive \$30 2 wisually Required (prior approval required) Image: Charge Standard Progressive \$30 \$30 D. Frame Provided: Addition Multifocals Image: Specience \$30 \$30	Secondary Diagnosis code (if any):					
2. Single Vision Bifocal Trifocal Image: Charge Dispense 2. Single Vision Bifocal Trifocal Image: Charge Dispense C. Contact Lenses: Premium Collection Lenses - Plan 1: Image: Charge Dispense Evaluation/Fitting Image: Charge State of the state of th			nal dispense will be paid			
C. Contact Lenses: Frame** \$25 \$10 Premium Collection Lenses - Plan 1: Ultraviolet \$12 \$6 Evaluation/Fitting Scratch-Resistant Included N/A 4 multi-packs* plan supplied Disposable lenses or: Scratch-Resistant Included N/A 4 multi-packs* plan supplied Disposable Specialty lenses or: Scratch Protection Plan \$20 \$10 2 multi-packs* plan supplied Planned Replacement lenses Scratch Protection Plan \$40 \$10 Provider Supplied: Evaluation/Fitting: Standard Specialty Standard Progressive \$40 \$10 Visually Required (prior approval required) Premium Progressive \$90 \$30		-				
Evaluation/Fitting Image: Conting \$12 \$6 4 multi-packs* plan supplied Disposable lenses or: Image: Conting Image: Conting Image: Conting Image: Conting Image: Conting \$12 \$6 4 multi-packs* plan supplied Disposable lenses or: Image: Conting N/A 4 multi-packs* plan supplied Disposable Specialty lenses or: Image: Conting Image: Conting Image: Conting Image: Conting Image: Conting N/A 2 multi-packs* plan supplied Planned Replacement lenses Image: Conting Image: Conting Image: Conting Scratch Protection Plan Scratch Protection Plan Standard Progressive Standard Progr		Frame**		\$25	\$10	
4 multi-packs* plan supplied Disposable lenses or:		Coating		\$12	\$ 6	
4 multi-packs* plan supplied Disposable Specialty lenses or:			nt 🛛	Included	N/A	
2 multi-packs* plan supplied Planned Replacement lenses □ Provider Supplied: Evaluation/Fitting: Standard □ Specialty □ Elective □ Visually Required (prior approval required) □ D. Frame Provided: □		Scratch Protection		\$20	\$10	
Provider Supplied: Evaluation/Fitting: Standard St	2 multi-packs* plan supplied Planned Replacement lenses	Scratch Protection	Plan	\$40	\$10	
Visually Required (prior approval required)Image: Constraint of the second		Standard Progress	sive			
Addition Multificats	Visually Required (prior approval required)		sive			
Plan Patient's Provider's D Ultra Progressive	D. Frame Provided: Plan Patient's Provider's P	Addition Multifo	ve	\$90	\$30	
Addition Multifocals S55		Addition Multifo	cals 🛛	\$140	\$55	
SECTION VI - SIGNATURE SECTION Polycarbonate Lenses*** Image: State Sta	SECTION VI - SIGNATURE SECTION	Lenses***		\$30	\$20	
A. I certify that all of the services and materials indicated above as received are indicated (anti-reflective coating)	A. I certify that all of the services and materials indicated above as received are indicated	Standard ARC (anti-reflective coa	tting)	\$35	\$ 7	
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				\$48	\$ 7	
items and costs as outlined in Sections IV and V, and I bear the full responsibility for (anti-reflective coating)		Ultra ARC		\$60	\$10	
payment of any charge associated with any of the items selected. I understand that Polarized		Polarized		\$75	\$25	
adapt to these lenses, standard bifocal lenses will be provided with no additional cost, High Index S55 \$25		High Index		\$55	\$25	
however, the copayment for the Progressive Addition Lenses will not be refunded Lenses 0000 TN Residents: Please see Instruction 6. Plastic Photosensitive				<i></i>	<i>\</i>	
Lenses 🗆 \$65 \$25				\$65	\$25	
Patient Signature * Number of contact lens boxes may vary based on manufacturer's packaging.	Patient Signature	* Number of contact lens box	es may vary based on ma	nufacturer's packs	iging.	
bate of Service ** For included Fashion and Designer level frames, a \$10 additional dispense will apply. *** No copayment/additional dispense for dependent children, monocular patients and	Date of Service	** For included Fashion and	Designer level frames, a \$	510 additional disp	ense will apply.	
B. I certify that all services were provided by me or by authorized personnel, in				,	F	
compliance with the standards of the Davis Vision Program. TN Providers: Please INSTRUCTIONS:		INSTRUCTIONS:				
see instruction 6. 1. Participating provider must complete Sections I,III, V, and VIB. 2. Employee or legal guardian should complete and sign Section VIA.	see instruction 6.					
3. All services rendered should be recorded on a single form.	Authorized Construe	3. All services rendered should	l be recorded on a single for	rm.	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	Autorized Signature	 Completed forms must be m Tennessee state law stipul 	naintained for a period of no lates that it is a crime to l	ot less than seven (7 knowingly provide) years. e false, incomplete or	
Invoice No misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.	Invoice No.	misleading information to an insurance company for the purpose of defrauding the				

SR03464 11/4/15

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.