HealthFirst Health Plan, Inc.

DavisVision™

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

NOTE: THIS IS AN AFFORDABLE CARE ACT POLICY. Benefits outlined below may be subject to cost sharing (i.e., Deductible and/or Co-Insurance Expense up to Maximum Out-Of-Pocket for covered services). Details to be provided at enrollment confirmation.

SECTION I - PATIENT/PROVIDER SECTION	
Member Name:	
Member ID No:	
Patient Name:	DOB:
Relationship: (circle one)	Member Spouse Partner Child
Provider's Name:	
Provider's No:	

SECTION II - ENROLLMENT CONFIRMATION
Enrollment Confirmation: YDS _____
Enrollment Confirmation Date:
*Patient Responsible for 100% of Benefit Value: (circle one): Yes No N/A
*Maximum Out-Of-Pocket Met[1]: (circle one) Yes No N/A
*Deductible Met[2] (circle one): Yes No N/A
*Co-insurance amount: 0%

*Not all portions of cost sharing apply to all plans. Deductible, Co-insurance and Maximum Out-Of-Pocket information provided at time of enrollment confirmation based on most recent information Davis Vision has received from the patient's medical carrier.

WHO IS ELIGIBLE?

SECTION III: ALLOWABLE SERVICES SECTION			
Examination - routine (including dilation)			
Coverage :	Patient Responsibility[3]	Benefit Value[4]	Provider Fee Schedule
Every January 1	$0	See Benefit Alert	See Benefit Alert on www.davisvision.com
Contact lenses Evaluation, Fitting, and Follow-up			
Coverage : Every January 1			
	See Non-Covered Services	See Non-Covered Services	
Frames			
Coverage : Every January 1			
Types :			
Fashion Selection from the "Exclusive Davis Vision Collection"	N/A	N/A	
Designer Selection from the "Exclusive Davis Vision Collection"	See Non-Covered Services	See Non-Covered Services	
Premier Selection from the "Exclusive Davis Vision Collection"	See Non-Covered Services	See Non-Covered Services	
Pediatric Selection from the "Exclusive Davis Vision Collection"	Co-insurance	$23.30	
Non-Selection Frame - *20% discount on balance	Amount over $100*	$100 + amount over $100*	
Spectacle Lenses			
Coverage : Every January 1			
Single Vision	Included*	$59.44	
Bifocal	Included*	$79.08	
Trifocal	Included*	$96.24	
Coverage: Contact Lenses			
Non-Selection Contact Lenses - *15% discount on balance	Amount over $100*	$100.00*	
Visually Required Contact Lenses (prior approval required) Materials, Evaluation, Fitting & Follow –Up Care	Included*	100% of Provider's charge	

[1] If Maximum Out-Of-Pocket is met, the patient only pays the non-covered services charges. If plan has a Maximum Out-Of-Pocket and the maximum has not been met, the patient is responsible to pay the 'patient responsibility', in addition to non-covered service charges.

[2] If plan is subject to Deductible and the Deductible is not met as of the date of service, the patient is responsible to pay the Benefit Value, in addition to any non-covered service charges. If the Deductible is met, the patient is responsible to pay only the non-covered service charges at the time of their initial visit. Remaining patient responsibility should be collected prior to dispensing eyewear.

[3] The patient responsibility is only applicable when a patient has met Deductibles; these charges should not be collected during the patient's initial visit. They should be collected if and when eyewear is dispensed.

[4] The Benefit Value becomes the patient's responsibility when a plan has a Deductible that has not been met. In the event that a lens enhancement is included as an allowable service, but the patient's Deductible has not been met, the patient is responsible to pay the Benefit Value.

You have specific ERISA appeals rights regarding your vision care benefits. These rights may be obtained in detail by contacting Davis Vision at 1.800.753.3311 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.

SECTION IV: NON-COVERED SERVICES		
	Patient Responsibility[3]	Additional Dispense
Frames:		
Designer Selection from the "Exclusive Davis Vision Collection"	$15.00	$10
Premier Selection from the "Exclusive Davis Vision Collection"	$40.00	$10
Lens Materials:		
Clear, Plastic	Included	N/A
Polarized	$75.00	$25.00
Polycarbonate Lenses	Included	N/A
High Index/Hi-Lite	$60.00	$25.00
Plastic Photosensitive Lenses	$70.00	$25.00
Types:		
Oversized Lenses	Included	N/A
Post Cataract Lenses	Included	N/A
Progressive Addition Multifocals		
Standard Types	$65.00	$30.00
Premium Types	$105.00	$30.00
Ultra Types	$140.00	$55.00
Intermediate Vision Lenses	$30.00	$10.00
Coatings/Tints:		
Solid or Gradient tint on Plastic Lenses	$15.00	N/A
Scratch Resistant Coating	Included	N/A
Ultraviolet Coating	Included	N/A
Scratch Protection Plan- SV	$20.00	$10.00
Scratch Protection Plan- MV	$40.00	$10.00
ARC (Anti-Reflective Coating)		
Standard Type	$40.00	$7.00
Premium Type	$55.00	$7.00
Ultra Type	$69.00	$10.00
Contact Lenses:		
Contact lenses Evaluation, Fitting, and Follow-up - 15% discount	Co-insurance	N/A

SECTION V: SERVICE SECTION

A. Examination
1a. Was Examination Comprehensive? (circle one) Yes No
1b. Was this a new Patient? Yes No
1c. Was Dilation performed? Yes No
1d. Diagnosis: _____

B. Spectacle Lenses provided (circle all that apply)
1. Plan Patients
2. Single Vision Bifocal Trifocal

C. Frame Provided: (circle one)
Selection Patients Non-Selection

D. Contact Lenses
Selection: (circle one) Disposable Planned Replacement OR Non-Selection: (circle one) Elective Visually Required (w/ prior approval)

SECTION VI: INSTRUCTIONS:

1. Participating provider must complete Sections I. II, V and VII.
2. Member or legal guardian should complete and sign section VII.
3. Confirmation is valid for 21 days. If expired, call 1.800.773.2847 prior to rendering services.
4. Completed forms must be maintained for a period of not less than seven(7) years.
5. Tennessee state law stipulates that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for purposes or defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SECTION VII: SIGNATURE SECTION

A. I certify that all of the services and materials 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 III and IV, 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 option will not be refunded. TN RESIDENTS: Please see instruction 5 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 5 at right.

Authorized Signature _____ Invoice No. _____