CareFirst BlueChoice, CareFirst BlueCross BlueShield Blue Vision Plus

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.: **ZK0** _____

Authorization Date: _____

SECTION II - COVERAGE SECTION

Plan Level: Premier

Copayments:		
	Eye examination	$10
	Frame** and/or Spectacle lenses	$0
	Contact Lenses:	
	Premium Collection lenses - Plan 1	$0

Plan Description:
An eye examination (including dilation), spectacle lenses and a frame or contact lenses in lieu of eyeglasses. Visually Required contact lenses may be provided with prior approval.
Please Note: Members are entitled to an additional eye exam if they have Diabetes, Hypertenstion, and/or Pregnancy.

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:

Premium Collection Lenses - Plan 1:

4 multi-packs* plan supplied Daily Disposable lenses or: ☐

4 multi-packs* plan supplied Disposable lenses or: ☐

4 multi-packs* plan supplied Disposable Specialty lenses or: ☐

2 multi-packs* plan supplied Planned Replacement lenses ☐

Provider Supplied:

Elective ☐

Visually Required (prior approval required) ☐

D. Frame Provided:

Plan ☐ Patient's ☐ Provider's ☐

SECTION IV - ALLOWANCE SECTION

Frame	Contact Lens Material	Visually Required Contact Lens Material
$100 plus 20% discount off overage	$97 single vision / $127 bifocal plus 15% discount off overage	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	☐	$12	$ 6
Scratch-Resistant Coating	☐	Included	N/A
Scratch Protection Plan Single Vision	☐	$20	$10
Scratch Protection Plan Multifocal	☐	$40	$10
Photochromic Lenses	☐	$20	$10
Blended Segments	☐	$20	$10
Intermediate Vision Lenses	☐	$30	$10
Standard Progressive Addition Multifocals	☐	$50	$30
Premium Progressive Addition Multifocals	☐	$90	$30
Ultra Progressive Addition Multifocals	☐	$140	$55
Polycarbonate Lenses***	☐	$30	$20
Standard ARC (anti-reflective coating)	☐	$35	$ 7
Premium ARC (anti-reflective coating)	☐	$48	$ 7
Ultra ARC (anti-reflective coating)	☐	$60	$10
Polarized Lenses	☐	$75	$25
High Index Lenses	☐	$55	$25
Plastic Photosensitive Lenses	☐	$65	$25

*** Number of contact lens boxes may vary based on manufacturer's packaging.**
**** For included Fashion, Designer and Premier 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.**

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. _____

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.

SR04435 4/2/21

You have specific ERISA appeals rights regarding your vision care benefits. These rights may be obtained in detail by contacting Davis Vision at 1-800-783-5602 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.