Pennsylvania Municipal Health Insurance Cooperative d/b/a PMHIC

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.: **0LW** _____

Authorization Date: _____

SECTION II - COVERAGE SECTION

Plan Level: Hybrid Affinity Gold

Copayments:	Eye examination	$0
Allowances:	Frame	$24
	Single Vision Spectacle lenses	$24
	Bifocal Spectacle lenses	$36
	Trifocal Spectacle lenses	$46
	Lenticular Spectacle lenses	$72
	Contact Lenses	$48

Plan Description:

Eye examination (including dilation), discount towards spectacle lenses and a frame or contact lenses in lieu of eyeglasses.

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:*

		Max charge:	Allowance		Patient Pays:
Single Vision	☐	$35 minus	$24	=	$11
Bifocal	☐	$55 minus	$36	=	$19
Trifocal	☐	$65 minus	$46	=	$19
Lenticular	☐	$110 minus	$72	=	$38

C. Contact Lenses: Member Pays:

Conventional ☐ 20% off U & C

Disposable/planned replacement ☐ 10% off U & C

Member Cost equals the discounted price of contacts minus $48 (allowance)

D. Frame Provided*:

Member Pays

Priced up to $70 retail ☐ $40

Priced above $70 retail ☐ $40 plus 10% off the amount over $70

Member Cost equals the discounted price of a frame minus $24 (allowance).

SECTION IV - OPTIONS SECTION*

Patient charges for selected options.
(in addition to lens price)

Option	☑	Patient Charge
Standard Progressive Lenses	☐	$75
Premium Progressive Lenses	☐	$125
Blended Invisible Bifocals	☐	$20
High Index	☐	$55
Polarized Lenses	☐	$75
Glass Lenses	☐	$18
Polycarbonate Lenses	☐	$30
Scratch-Resistant Coating	☐	$20
Standard ARC (anti-reflective coating)	☐	$45
Ultraviolet Coating	☐	$15
Solid Tint	☐	$10
Gradient Tint	☐	$12
Photochromic Lenses	☐	$35
Plastic Photosensitive Lenses	☐	$65
Intermediate Vision Lenses	☐	$30

*Special lens designs, materials, powers and frames may require additional cost. Prices represent maximum patient charges for the items listed.

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.

SR05756 11/14/22

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.