

# Building Service 32 B-J Health Fund/Boston Building Service Employees' Trust Fund

## 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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>
Provider's Name:	_____
Provider's No.:	_____
Authorization No.:	<b>BJL</b> _____
Authorization Date:	_____

SECTION II - COVERAGE SECTION	
Plan Level:	Designer
Copayments:	Eye examination \$0
	Frame and/or Spectacle lenses \$0
	Contact Lenses \$0
Plan Description:	An eye examination (including dilation), spectacle lenses and a frame or provider supplied contact lenses in lieu of eyeglasses.

SECTION III - SERVICE SECTION	
<b>A. Examination:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
1a. Was examination comprehensive?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1b. Was dilation performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1c. Was this a new patient?	Yes <input type="checkbox"/> No <input type="checkbox"/>
1d. Primary Diagnosis code:	_____
Secondary Diagnosis code (if any):	_____

SECTION IV - ALLOWANCE SECTION	
Frame	Contact Lens Material
\$100	\$120

<b>B. Spectacle lenses provided: (check all that apply)</b>
1. Plan <input type="checkbox"/> Patient's <input type="checkbox"/>
2. Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/>

SECTION V - OPTIONS SECTION			
Patient charges for selected options. Additional dispense will be paid by Davis Vision.			
Option	<input type="checkbox"/>	Patient Charge	Additional Dispense
Premier* Frame	<input type="checkbox"/>	\$20	\$10
Ultraviolet Coating	<input type="checkbox"/>	Included	\$ 6
Scratch-Resistant Coating	<input type="checkbox"/>	Included	N/A
Photochromic Lenses	<input type="checkbox"/>	Included	\$10
Blended Segments	<input type="checkbox"/>	Included	\$10
Intermediate Vision Lenses	<input type="checkbox"/>	Included	\$10
Standard Progressive Addition Multifocals	<input type="checkbox"/>	Included	\$30
Premium Progressive Addition Multifocals	<input type="checkbox"/>	\$40	\$30
Ultra Progressive Addition Multifocals	<input type="checkbox"/>	\$90	\$60
Polycarbonate Lenses**	<input type="checkbox"/>	Included	\$20
Standard ARC (anti-reflective coating)	<input type="checkbox"/>	\$35	\$ 7
Premium ARC (anti-reflective coating)	<input type="checkbox"/>	\$48	\$ 7
Ultra ARC (anti-reflective coating)	<input type="checkbox"/>	\$60	\$15
Polarized Lenses	<input type="checkbox"/>	\$75	\$25
High Index Lenses	<input type="checkbox"/>	\$55	\$25
Plastic Photosensitive Lenses	<input type="checkbox"/>	\$65	\$25

<b>C. Contact Lenses:</b>
<b>Provider Supplied:</b>
Elective <input type="checkbox"/>

<b>D. Frame Provided:</b>
Plan <input type="checkbox"/> Patient's <input type="checkbox"/> Provider's <input type="checkbox"/>

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. <b>TN RESIDENTS:</b> 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. <b>TN PROVIDERS:</b> Please see instruction 6 at right .	
Authorized Signature _____	
Invoice No. _____	

\* For included Fashion and Designer level frames, a \$10 additional dispense will apply.  
\*\* 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 VI.
2. Member or legal guardian should complete and sign Section VI.
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.

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You have specific ERISA appeals rights regarding your vision care benefits. These rights may be obtained in detail by contacting Davis Vision at 1-800-603-5633 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.