



PLEASE PRINT OR TYPE

1. Patient Name (First, M.I., Last)	2. Patient's Date of Birth MM DD YYYY	3. Insured's Name (First, Middle, Last)
4. Patient's Address (Street, City, State, Zip Code and Phone No.)	5. Patient's Sex M F <input type="checkbox"/> <input type="checkbox"/>	6. Insured's Identification Number
	7. Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	8. Insured's Group Number
9. Other Group Health Insurance Coverage (Name of Company and Address)	10. Was Condition Related to Job Injury? YES NO <input type="checkbox"/> <input type="checkbox"/>	11. Insured's Address (Street, City, State, Zip)

12. SERVICES PROVIDED (INDICATE DATE, CHARGE AND AMOUNT PAID)	DATE	CHARGE	AMOUNT PAID
VISION TESTING EXAMINATION 92002 _____			
FRAMES V2020 _____			
LENSES V2100 SINGLE VISION _____			
V2200 BIFOCAL VISION _____			
V2300 TRIFOCAL VISION _____ (additional information) _____			
TINT V2740 _____			
SCRATCH RESISTANT COATING V2760 _____			
CONTACT LENSES V250 SINGLE VISION _____			
V2502 BIFOCAL VISION _____ (additional information) _____ _____ _____			
TOTAL CHARGES ►			

13. I HEREBY CERTIFY THAT I AM ELIGIBLE TO RECEIVE THE COVERED SERVICES INDICATED ABOVE WITHIN THE PROVISIONS OF THE VISION CARE PROGRAM.

SIGNATURE OF MEMBER

14. I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED AND TO THE BEST OF MY KNOWLEDGE ARE WITHIN THE PROVISIONS OF THE VISION CARE PROGRAM.

SIGNATURE OF PROVIDER

15. PROVIDER'S NAME, ADDRESS, ZIP CODE