Please Forward Claims To:

MEDICAL EYE SERVICES (MES)
P.O. Box 25208, Santa Ana, CA 92799-5208
(800) 877-6372 (714) 619-4660
CSU Vision Plan is administered by Medical Eye Services (MES)

Blue Shield of California
Life & Health Insurance Company
An Independent Licensee of the Blue Shield Association

(PLEASE CHECK ONLY ONE BOX)

Claims Submitted For: **EXAM ONLY** ☐ **MATERIALS ONLY** ☐ **EXAM & MATERIALS** ☐

VISION CLAIM FORM GROUP POLICY NUMBER F21426

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTE: Please complete the entire enrollment form. This form cannot be processed if information is incomplete.

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

SECTION 1 – EMPLOYEE/PATIENT TO COMPLETE AND SIGN THIS SECTION

PATIENT'S NAME (LAST NAME FIRST)	GENDER ☐ MALE ☐ FEMALE	EMPLOYEE SOCIAL SECURITY NUMBER
EMPLOYEE'S NAME	RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE/DOM.PRTNR. ☐ CHILD	PATIENT'S BIRTHDATE MONTH DAY YEAR
STREET ADDRESS	NAME OF EMPLOYER CALIFORNIA STATE UNIVERSITY	CAMPUS
CITY, STATE, AND ZIP CODE		

OTHER VISION COVERAGE? IF "YES," GIVE NAME OF CARRIER AND POLICY NUMBER
☐ YES ☐ NO

WAS CARE REQUIRED BECAUSE OF AN INJURY OR ILLNESS? IF "YES," PLEASE EXPLAIN
☐ YES ☐ NO

The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize my doctor to furnish and disclose all facts concerning this claim. I hereby assign payable benefits to participating providers. if the patient is a minor, the form must be signed by the patient's legal guardian.

PATIENT SIGNATURE ______________________ DATE ____________

I certify that dependent shown above is eligible for benefits as defined in the Certificate of Coverage.

EMPLOYEE SIGNATURE ______________________ DATE ____________

SECTION 2 – TO BE COMPLETED BY DOCTOR

DATE OF EXAMINATION | REFRACTION | NO REFRACTION

IF YOU PRESCRIBED GLASSES, CHECK THE TYPE
☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ PROGRESSIVE ☐ CONTACT LENS

HAS CATARACT SURGERY BEEN PERFORMED?
☐ YES ☐ NO DATE:

CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? ☐ YES ☐ NO

IS THIS A PRESCRIPTION CHANGE FROM LAST YEAR? ☐ YES ☐ NO

BEST CORRECTED VISUAL ACUITY R.E. 20/ L.E. 20/

RVS/CPT

EXAMINATION FEE $

DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Base
R.E.	•	•			
L.E.	•	•			

READING ADD	R.E.	+ •	L.E.	+ •

SPECIAL INSTRUCTIONS

THERE IS A $10.00 COPAYMENT PER 12-MONTH PERIOD.

SIGNATURE	DATE
PLEASE TYPE OR PRINT NAME OF DOCTOR	ECN PROVIDER NO.

STREET ADDRESS

CITY, STATE, AND ZIP CODE

PROVIDER AUTHORIZATION NO.

SECTION 3 – TO BE COMPLETED BY DISPENSER

DATE OF ORDER | DATE OF DELIVERY | ☐ SINGLE VISION ☐ TRIFOCAL ☐ BIFOCAL ☐ PROG

RIGHT LENS CHARGE	$
LEFT LENS CHARGE	$
OVERSIZE CHARGE, IF ANY	$
☐ PRISM CHARGE ☐ OTHER ☐ SLAB OFF CHARGE ______	$
TINT CHARGE COLOR ______ NO. ______	$
FRAME CHARGE NAME OF FRAME ______	$
IS FRAME SIZE LESS THAN 61 MM?`	☐ YES ☐ NO
CONTACT LENS CHARGE ☐ HARD ☐ SOFT	$
TOTAL FOR OPTICAL MATERIALS	$

COMMENTS

THERE IS A $90.00 RETAIL FRAME ALLOWANCE THROUGH PARTICIPATING PROVIDERS.

SIGNATURE	DATE
PLEASE TYPE OR PRINT NAME OF DISPENSARY	ECN PROVIDER NO.

STREET ADDRESS

CITY, STATE, AND ZIP CODE

PROVIDER AUTHORIZATION NO.