

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)

(PLEASE CHECK ONLY ONE BOX)

Claims Submitted For: EXAM ONLY MATERIALS ONLY EXAM & MATERIALS



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

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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	EMPLOYEE SOCIAL SECURITY NUMBER
EMPLOYEE'S NAME	RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE/DOM.PRTNR. <input type="checkbox"/> 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 BEST CORRECTED VISUAL ACUITY _____

CHANGE FROM LAST YEAR? YES NO 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 _____

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 _____