**SECTION I - PROVIDER/PATIENT SECTION**

Member Name: ____________________________

Member ID No.: __________________________

Patient Name: ____________________________

Relationship: Member __ Spouse __ Child __

Provider’s Name: _________________________

Provider’s No.: __________________________

Authorization No.: ________________________

Authorization Date: ________________________

**SECTION II - COVERAGE SECTION**

Plan Level: Designer

Prefix: FDC, FDF, FDD*

Copayments:
- Eye examination $0
- Frame and/or Spectacle lenses $0
- Contact Lenses: Collection lenses $0

Plan Description:
An eye examination (including dilation), spectacle lenses and a frame or contact lenses in lieu of eyeglasses.

*Materials are covered only after post cataract surgery.

Post Cataract benefit: 1 pair of eyeglasses or contact lenses following each cataract surgery with insertion of an intraocular lens with prior approval. Medically necessary contact lenses may be provided with prior approval.

**SECTION III - SERVICE SECTION**

A. Examination:
   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: (check all that apply)
   1. Plan __ Patient’s __
   2. Single Vision __ Bifocal __ Trifocal __

C. Contact Lenses:

Collection Lenses:
- 4 multi-packs plan supplied Disposable lenses or: __
- 2 multi-packs plan supplied Planned Replacement lenses __

Provider Supplied:
- Elective __
- Medically Necessary (prior approval required) __

D. Frame Provided:
   Plan __ Patient’s __ Provider’s __

**SECTION IV - ALLOWANCE SECTION**

<table>
<thead>
<tr>
<th>Frame Material</th>
<th>Contact Lens Material</th>
<th>Medically Necessary Contact Lens Material</th>
</tr>
</thead>
<tbody>
<tr>
<td>$40 (wholesale)</td>
<td>$100</td>
<td>Paid in full (prior approval required)</td>
</tr>
</tbody>
</table>

**SECTION V - OPTIONS SECTION**

Patient charges for selected options. Additional dispense will be paid by Davis Vision.

<table>
<thead>
<tr>
<th>Option</th>
<th>Charge</th>
<th>Add'l Dispense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premier Frame</td>
<td>$25</td>
<td>N/A</td>
</tr>
<tr>
<td>Ultraviolet Coating</td>
<td>$12</td>
<td>$6</td>
</tr>
<tr>
<td>Scratch-Resistant Coating</td>
<td>$20</td>
<td>$10</td>
</tr>
<tr>
<td>Photochromic Lenses</td>
<td>$20</td>
<td>$10</td>
</tr>
<tr>
<td>Blended Segments</td>
<td>$20</td>
<td>$10</td>
</tr>
<tr>
<td>Intermediate Vision Lenses</td>
<td>$30</td>
<td>$10</td>
</tr>
<tr>
<td>Standard Progressive Addition Multifocals</td>
<td>$50</td>
<td>$30</td>
</tr>
<tr>
<td>Premium Progressive Addition Multifocals</td>
<td>$90</td>
<td>$30</td>
</tr>
<tr>
<td>Polycarbonate Lenses*</td>
<td>$30</td>
<td>$20</td>
</tr>
<tr>
<td>Standard ARC (anti-reflective coating)</td>
<td>$35</td>
<td>$7</td>
</tr>
<tr>
<td>Premium ARC (anti-reflective coating)</td>
<td>$48</td>
<td>$7</td>
</tr>
<tr>
<td>Polarized Lenses</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>High Index Lenses</td>
<td>$55</td>
<td>$25</td>
</tr>
<tr>
<td>Plastic Photosensitive Lenses</td>
<td>$65</td>
<td>$25</td>
</tr>
</tbody>
</table>

* No copayment/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 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.

You have specific ERISA appeals rights regarding your vision care benefits. These rights may be obtained in detail by contacting Davis Vision at 1-800-601-3383 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.