Enrollment/Change Form

FOR GROUPS

Western Health Advantage

NEW ENROLLMENT

☐ New group ☐ Open enrollment

☐ New hire — date of hire: _____

☐ Newly eligible — reason: _____

_____

☐ COBRA — effective date: _____

Directions: Complete entire form. **Select a primary care physician** (PCP) for yourself and each family member from the Provider Directory and write his/her name and ID# in the designated area.

CHANGE

For Changes, Member ID#: _____

☐ Add dependent*

☐ Add newborn/newly adopted child *

☐ Remove dependent — effective: _____

☐ Change of name ☐ Change of address

* Date of qualifying event (if not open enrollment): _____

Directions: Complete the bolded information (required) in Section I and any sections applicable to the change you are making.

PLAN SELECTION [ ] Gateway 30 [ ] Gateway 2000 [ ] Gateway 4010
[ ] Gateway 70 [ ] Gateway 1500 [ ] Gateway 6500

PLAN INFORMATION

Employer_____ **Benefit Plan** _____ **Effective Date** _____

Group #_____ **Class** _____ **Subgroup** _____

SECTION I — MEMBER INFORMATION

Employee First Name_____ **Last Name**_____ **MI**_____

Social Security Number_____ **Date of Birth**_____ **Gender ☐ Male ☐ Female**

Residential Street Address (required)_____ **Apt./Unit#**_____

City, State, Zip _____

Mailing Address (if different)_____ Apt./Unit#_____

City, State, Zip _____

Email Address_____ Job Title_____

Home Phone_____ Work Phone _____

PCP Name_____ ID#_____ Medical Group _____

Existing Patient ☐ Yes ☐ No

Are you of Latino, Hispanic or Spanish origin? ☐ Decline to State ☐ Yes ☐ No
How would you describe your race? Check all that apply. ☐ Decline to State ☐ White/Caucasian ☐ American Indian/Alaska Native ☐ Asian
Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other _____
What language do you feel most comfortable speaking? ☐ Decline to State ☐ English ☐ Spanish ☐ Other _____
What language do you prefer for written materials? ☐ Decline to State ☐ English ☐ Spanish ☐ Other _____
What language do you feel most comfortable speaking? ☐ Decline to State ☐ English ☐ Spanish ☐ Other _____

SECTION II — DEPENDENT INFORMATION

☐ Add ☐ Remove ☐ Spouse ☐ Domestic Partner Gender ☐ Male ☐ Female

First Name_____ Last Name_____ MI_____

Social Security Number_____ Date of Birth_____ Existing Patient ☐ Yes ☐ No

PCP Name_____ ID#_____ Medical Group _____

Are you of Latino, Hispanic or Spanish origin? ☐ Decline to State ☐ Yes ☐ No
How would you describe your race? Check all that apply. ☐ Decline to State ☐ White/Caucasian ☐ American Indian/Alaska Native ☐ Asian
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other _____
What language do you feel most comfortable speaking? ☐ Decline to State ☐ English ☐ Spanish ☐ Other _____
What language do you prefer for written materials? ☐ Decline to State ☐ English ☐ Spanish ☐ Other _____

Employee First Name_____ Last Name _____

☐ Add ☐ Remove ☐ Child, up to age 26 ☐ Disabled (must meet criteria and provide proof of disability) Gender ☐ Male ☐ Female

First Name_____ Last Name_____ MI_____

Social Security Number_____ Date of Birth_____ Existing Patient ☐ Yes ☐ No

PCP Name_____ ID#_____ Medical Group _____

Are you of Latino, Hispanic or Spanish origin? ☐ Decline to State ☐ Yes ☐ No
How would you describe your race? Check all that apply. ☐ Decline to State ☐ White/Caucasian ☐ American Indian/Alaska Native ☐ Asian
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other _____
What language do you feel most comfortable speaking? ☐ Decline to State ☐ English ☐ Spanish ☐ Other _____
What language do you prefer for written materials? ☐ Decline to State ☐ English ☐ Spanish ☐ Other _____

☐ Add ☐ Remove ☐ Child, up to age 26 ☐ Disabled (must meet criteria and provide proof of disability) Gender ☐ Male ☐ Female

First Name_____ Last Name_____ MI_____

Social Security Number_____ Date of Birth_____ Existing Patient ☐ Yes ☐ No

PCP Name_____ ID#_____ Medical Group _____

Are you of Latino, Hispanic or Spanish origin? ☐ Decline to State ☐ Yes ☐ No
How would you describe your race? Check all that apply. ☐ Decline to State ☐ White/Caucasian ☐ American Indian/Alaska Native ☐ Asian
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other _____
What language do you feel most comfortable speaking? ☐ Decline to State ☐ English ☐ Spanish ☐ Other _____
What language do you prefer for written materials? ☐ Decline to State ☐ English ☐ Spanish ☐ Other _____

Use additional forms if necessary to provide information for all dependents.

SECTION III — OTHER HEALTH COVERAGE INFORMATION

Do any of the enrollees have other health coverage or Medicare? If yes, please complete this section.

Name(s) of Insured_____ Insurance Company_____ Effective Date _____

Subscriber of Coverage_____ Policy# / Medicare Claim #_____ ☐ Primary ☐ Secondary

Name(s) of Insured_____ Insurance Company_____ Effective Date _____

Subscriber of Coverage_____ Policy# / Medicare Claim #_____ ☐ Primary ☐ Secondary

SECTION IV — SIGNATURE REQUIRED

By signing below, I acknowledge that I have read, understand and agree to the terms and arbitration agreement stated below. A reproduction of this form shall be valid as an original.

A. On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage offered by Western Health Advantage (WHA) through my Employer, and agree to be bound by the WHA Group Service Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.

B. ARBITRATION AGREEMENT: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (INCLUDING ANY HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVANTAGE, INCLUDING CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR SMALL CLAIMS COURT CASES AND CLAIMS SUBJECT TO ERISA, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE PARTIES, INCLUDING ANY HEIRS OR ASSIGNS, TO THIS ARBITRATION AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Employee signature:_____ Date: _____

To the best of my knowledge the information contained herein is true and accurate. I hereby attest that employees and dependents submitted to WHA for coverage meet all eligibility requirements set forth in the Group Service Agreement between WHA and the employer group.

Employer signature:_____ Date: _____

KAISER PERMANENTE®

Small Business
EMPLOYEE ENROLLMENT

See instructions on page 1 before completing this form. Make a copy for your records.

PLAN SELECTION

[ ] Platinum 90 0/10
[ ] Platinum 90 0/15
[ ] Gold 80 0/30
[ ] Gold 80 500/35
[ ] Gold 80 HRA 2000/30
[ ] Silver 70 1000/50
[ ] Silver 70 2000/45
[ ] Silver 70 HDHP 2000/20%
[ ] Bronze 60 4800/40%
[ ] Bronze 60 6300/75

A TO BE COMPLETED BY EMPLOYER

☐ New group account ☐ Existing account

Company name	Customer ID (if assigned)	Date of coverage to be effective / /
Plan selection	Employee classification (*if applicable*)	
Employee name	Date of hire / /	

Enrollment reason *(Please check one.)* ☐ New group account ☐ New hire ☐ Open enrollment

☐ Part-time to full-time / / ☐ Loss of coverage / / ☐ Other: Event date / /

B TO BE COMPLETED BY EMPLOYEE

Have you ever been a member of, or received care from, Kaiser Permanente in California? ☐ Yes ☐ No

If so, under what medical record number (if known)	Former/Maiden name	
Name (Last, First, MI)	Social Security number	Preferred language (optional)

Home address (no P.O. boxes)	First day of residency at this address / /	City	State	ZIP

Date of birth / /	Gender ☐ M ☐ F	Home phone ( ) –	Office phone ( ) –

C FAMILY INFORMATION (Please list only those family members to be enrolled.)

☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	

☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	

☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	

☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	

Do any of your dependents listed above live at another address? ☐ Yes ☐ No If Yes, complete the following:

Name (Last, First, MI)	Address

Tear along dotted line.

D SIGNATURE

KAISER FOUNDATION HEALTH PLAN, INC., AND KAISER PERMANENTE INSURANCE COMPANY ARBITRATION AGREEMENT*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC),* any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage* and in the *Certificate of Insurance*.

Employee signature X	Date
Employee name (please print)	Title (please print)

**Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service (POS) Plan; 2) the Preferred Provider Organization (PPO) and Out-of-Area Indemnity (OOA) Plans; and 3) the KPIC Dental plans.*

E FAMILY INFORMATION (additional dependents)

☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	

HSA Authorization Form

FOR GROUP HEALTH COVERAGE

HealthEquity
Building Health Savings℠

As a benefit of your membership on an HSA-compatible health plan with Western Health Advantage, you have access to a Health Savings Account (HSA) with WHA's partner, HealthEquity, with no setup or monthly fees.* This partnership also allows WHA to communicate information about your claims directly to HealthEquity, making it easier for you to compare your financial responsibility under insurance with your payments from your HSA.

This signed HSA Authorization Form must be returned with your WHA Enrollment/Change Form in order for you to be enrolled in this benefit.

ELIGIBILITY REQUIREMENTS FOR A HEALTH SAVINGS ACCOUNT (HSA)

This HSA Authorization Form regards the establishment of an HSA that is used to accumulate assets for the payment of qualified health care expenses. Your HSA is your financial asset even if you change health plans or employers. Please note, however, that a change to your health plan will inactivate WHA's arrangement with HealthEquity. This may result in monthly fees for your HSA with HealthEquity.

To be eligible to open an HSA you must meet the following requirements:**

1. If you are currently participating in the General-Purpose Medical FSA, you must have a zero balance on December 31 of any calendar year in order to be HSA-eligible on January 1 of the following calendar year. That means that claims must be incurred and filed in time to be reimbursed with the last FSA check process of the year that will occur on December 31 of the initial year.

As of the effective date:

2. You must be covered by an HSA-qualified High Deductible Health Plan (HDHP) and must not be covered by other health insurance that is not an HDHP. Certain types of insurance (e.g., dental, vision, disibility and long-term care) are not considered "health insurance" and will not jeopardize an individual's eligibility for an HSA.
3. You cannot be covered by another health plan, including Medicare.
4. You cannot have an HSA if a spouse's FSA or HRA can pay for any medical expenses before the HDHP deductible is met.
5. You cannot be claimed as a dependent on another individual's tax return.
6. You must be 18 years of age or older.

*Note: If you do not elect to switch from paper to electronic statement delivery, the account includes a $1/month paper statement fee. This can be changed at the time you activate your debit card, or any time through your HealthEquity Member Portal.

**Neither Western Health Advantage nor HealthEquity provides medical or tax advice. Content should not in any case replace professional medical or tax advice. If you have questions regarding a medical condition, please consult a qualified healthcare professional. All tax references are on the federal level. State taxes may vary. Please consult your tax advisor.

Primary Account Holder Information

Effective Date _____

Employer _____ WHA Group # _____

Employee Last Name _____ First Name _____ MI _____

Authorization and Certification

- I hereby certify that I meet the HSA Eligibility Requirements outlined above.
- I understand that, in compliance with the USA Patriot Act, HealthEquity must verify the identity of all customers seeking to open an HSA, and that I may be contacted to provide additional information and/or documentation if this is required to comply with the Act.
- I understand that, with this signed Authorization, a HealthEquity HSA will be opened for me as part of my enrollment with WHA.
- I authorize WHA to disclose my claims data to HealthEquity after my HSA is established in order to make that information available to me for reconciliation with my HSA.

_____ _____

Signature Today's Date

FDIC

The balance in your HSA is insured by the Federal Deposit Insurance Corporation (FDIC), subject to applicable deposit limits.

Western Health Advantage

DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA
DUAL CHOICE
Delta Dental of California

www.deltadentalins.com

Select a Plan: ❑ DPO / PPO OR ❑ DeltaCare® USA HMO[1]

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State

Effective Date / /	Hire Date / /

Name of Employer

Location	Pay Code	Benefit Package

Enrollee/Change Information

❑ New Enrollment ❑ Address Change ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

❑ Add/Delete Dependent ❑ Terminate Enrollee Coverage

❑ Marital Status Change ❑ Change Dental Plans*

Change Dental Plan*

❑ Fee-For-Service - Cancel

❑ DeltaCare USA - Cancel

*Enrollees can change plans only during open enrollment or due to a qualifying status change unless allowed by the group contra ct.

Enrollee Classification

❑ Full-Time ❑ Hourly ❑ Certified

❑ Part-Time ❑ Salaried ❑ Classified

❑ Retired ❑ Member/Other _____

COBRA (if applicable)

❑ Termination

❑ Reduction in Hours

❑ Divorce/Legal Separation**

❑ Widowed/Surviving Dependent**

❑ Dependent Child No Longer Eligible**

Indicate qualifying date: / /

**If a dependent is enrolling under his/her social security number, the SSN currently enrolled under must be provided.

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	❑ Male ❑ Female	❑ Single ❑ Married

First Name	Last Name	Middle Initial

Mailing Address (Street)	City	State	Zip Code

E-mail Address (internal use only)	Phone Number ( ) -	Phone Type Cell ❑ Work ❑ Home ❑

Network Facility Name (DellaCare USA only)	Network Facility Number (DeltaCare USA only)

Name of Olher Dental Carrier	Policy Holder Name (first/last)	Date of Birth
		/ /

Effective Date of Other Policy	Policy Holder Street Address	City	State	Zip Code
/ /				

Dependent Information

Relationship	Dependent First Name (last name only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled***	Name of School (overage student)***	Network Facility Number ‡ (DellaCare USA only)
Spouse/Partner		❑ ❑		/ /	❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑		

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. ***Addi tional documentation will be required for disabled and student st atus. ‡Maximum of three facilities per family.

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event , or as may otherwise be provided by the group contract.

❑ I decline coverage at this time.

Signature of Enrollee _____ Date _____/_____/_____

[1]DellaCare USA is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enr ollees must select a primary care dentist in the DellaCare USA network from whom they receive treatment.

MESVision

PLAN SELECTION [ ] 12/24/24 Plan [ ] 12/12/24 Plan

VISION PLAN ENROLLMENT/CHANGE REQUEST

Employee Effective Date:

EMPLOYEE INFORMATION

Current Last Name:		First Name:	MI:
Address:	Employee ID Number/Social Security Number	Date of Birth (mm/dd/yyyy)	
City:	State:	Zip Code:	Date of Hire:
Group Name:		MES Group Number:	

PLEASE ENROLL/CHANGE MY PLAN AS INDICATED

☐ New Enrollee ☐ Add dependent(s) ☐ Delete dependent(s) If adding spouse, give marriage date:

Eligible dependents are your spouse and unmarried children within the ages stated in your evidence of coverage.
Coverage granted to individuals listed hereon shall be subject to all provisions and limitations of the MESVision evidence of coverage.

☐ Change my name as shown. My former name is:

LIST BELOW ALL DEPENDENTS

Effective Date	Change	Relationship	Sex	First Name	MI	Last Name	Date of Birth (mm/dd/yyyy)	Full-time Student?
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No

SIGNATURE: ______________________________ DATE: ________________

PLEASE SUBMIT THIS FORM TO YOUR EMPLOYER

NOTE TO GROUP ADMINISTRATORS

Submit this form to Medical Eye Services for initial group enrollment only. All additions or changes to the original group enrollment should be reported on the Eligibility Control Form and submitted with your monthly premiums.

AMES-GRENZ
Insurance Services, Inc.

DISCLOSURE

Attention: If you are enrolling in a Deductible Plan through the Association, this signed letter of understanding must accompany your application.

The Deductibles and Out of Pocket Maximums of these plans are based on a Calendar Year.

Please remember this is a calendar year deductible, not plan year. Any expenses you accrue will apply to the Deductible and Out of Pocket Maximum for the Calendar Year, which starts January 1 and ends December 31, EVEN if you enroll in a month other than January.

Example: If you enroll in the plan in October and accrue expenses for October, November and December, whether you have met the deductible or not, a new Deductible and Out of Pocket maximum will begin in January of the following year.

*** Deductibles are always Calendar Year***

I understand the above information regarding Deductibles and Out of Pocket maximums.

_____ _____

Association Member Spouse

_____Date _____Date

Office: 916-486-2900 Toll-Free 888-338-2900 Fax: 916-486-4936
3435 American River Dr., Suite C • Sacramento, CA 95864 • www.amesgrenz.com
Lic# 0787081

Date: _____ /_____ / _____

Dear American River Benefit Administrators:

I _____, am a member of _____
(Member Name) (Association Name)
Member number _____.

I would like my employee, _____, to have the ability to enroll in insurance benefits through the Association. He/She has completed the 30 day waiting period for eligibility in the insurance plans.

Sincerely,

X_____

_____
(Title)

AUTHORIZATION FOR AUTOMATIC WITHDRAWAL
AMERICAN RIVER BENEFIT ADMINSTRATORS
Fax # 916-486-2615

Authorization for Automatic Withdrawal

I hereby authorize AMERICAN RIVER BENEFIT ADMINISTRATORS to automatically withdraw my monthly premium (s) from an account held in my name, at the referenced financial institution. I understand that any authorized transfer will be processed through the Automated ClearingHouse System. These transfers will be made on the specified date. If that date is on a day on which the Bank and the Automated ClearingHouse are not open for processing such transfers, transfers will be processed on the following business day on which both are open for such transfers.

Account Name _____

Account Number _____ Checking / Savings

Routing Number _____

Withdrawal Date 5th of the month 15th of the month 20th of the month

(Please circle your indication)

This authorization will remain effective until I give thirty (30) days written notice to the contrary and there has been a reasonable amount of time to act on such notice.

Date _____

Effective Payment Date _____ Client # _____

Customer Signature _____

PLEASE PLACE YOUR VOIDED / CANCELLED CHECK HERE

MESVision®

PO Box 25209 • Santa Ana, CA 92799-5209
(714) 619-4660 (800) 877-6372 TTY/TDD (877) 735-2929
MESVision.com

The Participating Provider Must Call MESVision to obtain an Eligibility Verification Number

PLEASE USE BLACK INK ONLY

INSURED / PATIENT PORTION

PATIENT'S NAME (Last Name, First)

GENDER ☐ MALE ☐ FEMALE

EMPLOYEE'S IDENTIFICATION NO.

EMPLOYEE'S NAME

RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ DOMESTIC PARTNER ☐ DOMICILE ADULT ☐ DISABLED

PATIENT'S BIRTHDATE MONTH DAY YEAR

ADDRESS

NAME OF EMPLOYER

GROUP POLICY NUMBER

CITY, STATE, and ZIP CODE

WAS CARE REQUIRED BECAUSE OF AN INJURY OR ILLNESS? ☐ NO ☐ YES

IF "YES," PLEASE EXPLAIN:

E-MAIL

IS PATIENT FULL TIME STUDENT? ☐ NO ☐ YES SCHOOL NAME:

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

POLICY NUMBER:

NAME OF CARRIER:

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.

SIGNATURE **DATE**

EXAMINER / DISPENSER PORTION

VERIFICATION #:

CHECK CONDITIONS PATIENT IS KNOWN TO HAVE

☐ DIABETES ☐ HIGH CHOLESTEROL ☐ HYPERTENSION ☐ GLAUCOMA

OTHER CONDITIONS/ DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD 9 / 10 Codes)

Diagnosis : _____ - _____ Diagnosis : _____ - _____

Diagnosis : _____ - _____ Diagnosis : _____ - _____

DIALATION : ☐ YES ☐ NO

RETINAL PHOTOS : ☐ YES ☐ NO

PRESCRIBED

☐ **Single Vision** ☐ **Bifocal** ☐ **Trifocal** ☐ **Progressive** ☐ **Contacts**

Rx	Sphere	Cylinder	Axis	Prism	Base Curve
R.E.					
L.E.					

READING ADD R.E. + L.E. +

EXAM DATE:

CL FITTING DATE:

HCPC/CPT CODES	CHARGES
	$
	$
	$
	$
TOTAL EXAM CHARGES	$ 0

NAME OF DOCTOR

PARTICIPATING PROVIDER NO.

EMAIL ADDRESS

NPI NO.

ADDRESS

CITY, STATE and ZIP CODE

SIGNATURE DATE

VERIFICATION #:

DATE OF ORDER:

DELIVERY DATE:

HCPC/CPT CODES	EYEWEAR	CHARGE
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
CONTACTS	BRAND	$
FRAME IS FRAME SIZE LESS THAN	FRAME NUMBER ☐ 56 ☐ 61	$
PLANO SUNGLASSES (PRE FABRICATED / NON-RX)	PROOF OF LASIK SURGERY MAY BE REQUIRED FOR SUNGLASS BENEFIT	$
COB: List the total overage on this line COB itemized charges above must be patient out of pocket		$
TOTAL FOR OPTICAL MATERIALS		$ 0

NAME OF DISPENSARY

PARTICIPATING PROVIDER NO.

EMAIL ADDRESS

NPI NO.

ADDRESS

CITY, STATE and ZIP CODE

SIGNATURE DATE

Rev 2012

For your protection, State 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.