Medical Eye Services of Oregon, Inc.

PO BOX 8184 PORTLAND, OR 97207
503-223-6376 800-882-6376

PLEASE FORWARD CLAIMS TO MEDICAL EYE SERVICES OF OREGON AT THE ABOVE ADDRESS

Part 1. TO BE COMPLETED AND SIGNED BY THE INSURED

Patient's Name (last name, first name)	PATIENT ☐ MALE ☐ FEMALE	EMPLOYEE SOCIAL SECURITY NUMBER
Employee's Name	PATIENT'S BIRTHDATE MONTH DAY YEAR	NAME OF EMPLOYER
Street Address		
City, State and Zip Code Phone Number	GROUP POLICY NUMBER R1011	RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD

Other Vision Coverage? If "yes", give name of carrier and policy number. ☐ YES ☐ NO

Was care required because of an injury? If yes, please answer the questions below. ☐ YES ☐ NO

Was injury caused by your work? ☐ YES ☐ NO

Have you filed a claim for this disability with the worker's compensation carrier? ☐ 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 participation providers.

Signature _____ Date _____

PART 2—TO BE COMPLETED BY DOCTOR

DATE IF EXAMINATION	REFRACTION	
	NO REFRACTION	

IF YOU PRESCRIBED LENSES, CHECK TYPE:
single vision bifocal trifocal contact

HAS CATARACT SURGERY BEEN PERFORMED? ____YES ____NO

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

R.V.S. NUMBER: EXAM FEE $

DOCTOR'S PRESCRIPTION

Sphere		Cylinder	Axis	Prism	Base
R.E.					
L.E.					
Reading Add		R.E.	+	L.E.	-

PART 3—TO BE COMPLETED BY DISPENSER

ORDER DATE	DELIVERY DATE	GLASS LENS	
		PLASTIC LENS	

CHECK IF OVER 65 MM BLANK ☐ RIGHT ☐ LEFT

OVERSIZE CHARGE: _____

PLASTIC CHARGE: _____

PRISM CHARGE: _____

SLAB OFF CHARGE: _____

TINT CHARGE: _____
COLOR _____
NUMBER _____

FRAME CHARGE: _____
NAME OF TYPE _____

CONTACT LENS CHARGE: HARD SOFT _____

TOTAL OPTICAL CHARGES: ***$*** _____

PLEASE CONTACT MESO AT 503-223-6376 / 800-882-6376 FOR BENEFITS AND ELIGIBILITY

SIGNATURE	DATE	SIGNATURE	DATE
TYPE OR PRINT NAME OF DOCTOR	NPI NUMBER	TYPE OR PRINT NAME OF DISPENSERY	NPI NUMBER
STREET ADDRESS		STREET ADDRESS	
CITY, STATE, ZIP CODE	PHONE NUMBER	CITY, STATE, ZIP CODE	PHONE NUMBER