U & M Family Eyecare Insurance Form

Please take a few minutes to fill out this form as completely as you can. If you have any questions, it will be a pleasure to assist you.

Patient Name: _____ Birthdate: _____

Insurance Information: Please provide your insurance card to the doctor's assistant

Card Holder/Member's Name: _____ SS#: _____
Member's DOB: _____ Relation to member _____ Self _____ Spouse ___ Child
Employer _____ Vision Ins.Company _____Group#: _____
Medical Insurance Co. _____ ID/Ins Grp# _____
Medicare ID #: _____ Secondary Ins & ID # _____

I do not have vision or medical insurance _____ (please check if this applies)
I am not filing vision or medical insurance _____(please check if this applies)

Please Read and understand the following:

U & M Family Eyecare will be happy to file your Insurance Claim for your eye examination. Your claim will be filed to your **vision** insurance if it is **routine** examination. Your claim will be filed to your **medical** insurance if there is a **medical diagnosis**. All professional fees are **non-refundable.**

Routine Eye Exams are defined as: An examination of the visual system void of any medical eye conditions such as diabetes, glaucoma, macular degeneration, cataracts, allergies or contact lens complications etc.

- **Medical Insurance DOES NOT cover a routine eye examination.**
- **Your medical insurance WILL cover a comprehensive MEDICAL examination IF there is a MEDICAL** diagnosis.
- **Our Comprehensive Medical Eye Examination fees are based on Medicare fee guidelines**
- **Medical Insurance DOES NOT cover refractions for which there is a $20.00 fee.**
- **Medical Insurance DOES NOT pay for contact lens fittings**
- Medicare patients will be required to pay **20%** of the examination cost today unless you have supplemental insurance which will cover the balance
- Medical Insurance holders will be required to pay appropriate co-pays as agreed upon by your insurance carrier. Please be aware that you must meet your deductible FIRST **before** your medical insurance will pay for services rendered. You will be sent a bill for the balance due if you have not met your deductible.
- If YOUR **medical** or **vision** insurance does not pay for any services rendered, **you will ultimately be responsible for all monies owed. If you fail to pay your bill it will be sent to collections. You agree that you will be responsible for any legal fees associated with paying your bill.**
- By signing below, you understand and agree with all said statements and allow us to file your claim.
- By signing below, I authorize the release of any medical or other information necessary to process this claim.
- I authorize payment of medical benefits of the undersigned physician or group for services rendered.

X_____
Signature Date