



VISION SERVICE REPORT

Mail To:
Mutual Medical Plans, Inc.
P.O. Box 689
Peoria, IL 61652

1. Patient Name: First Middle Initial Last			2. Relationship To Emp. (Self, Spouse, Dtr., Son)		3. Sex (M, F)	4. Pt. Birth Date (Mo., Day, Yr.)		5. If Full Time Student: School & City	
6. Employee Name (First, Initial, Last)		7. PHONE			8. Member Number (From ID Card)				
9. Mailing Address (Street, City, State, Zip Code)									
10. Name of Employer or Group		10A. Place of Employment - Spouse							
11. Is Patient Covered By Another Vision Plan? (Yes/No)		If Yes, Policy Holder ID No.			12. Name and Address of Other Insurance Company				
PATIENTS AUTHORIZATION: I HEREBY ACCEPT THE FOLLOWING TREATMENT PLAN AND AUTHORIZE THE RELEASE OF ANY INFORMATION RELATIVE TO THIS CASE					Signed (Patient, or Parent if Minor)		Date		

STATEMENT OF PROVIDER

INDICATE NATURE OF VISION DISORDER, DISEASE OR INJURY

PRESCRIPTION WRITE EXACTLY AS PRESCRIBED		SPHERE	CYLINDER	AXIS	PRISM	ADD
	R. EYE					
L. EYE						

THE PRESCRIBED LENSES ARE:

Aphakic Lenses Changed from Previous Lenses
 Same Prescription as Previous Lenses

	DATE OF PRESCRIPTION	PRESCRIPTION NUMBER

CHARGES FOR EXAMINATION, LENSES AND FRAMES

1. EXAMINATION DATE OF EXAM _____
 THE EXAM INCLUDED: REFRACTION RETINOSCOPY TONOMETRY

TOTAL EXAM CHARGE \$ _____

2. LENSES DATE ORDERED _____ DATE DISPENSED _____

SINGLE VISION		BI-FOCALS		TRI-FOCALS		LENTICULAR		CONTACTS	
R	L	R	L	R	L	R	L	R	L
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

TOTAL LENSES CHARGE \$ _____

FRAME CHARGE \$ _____

MFR. _____ TRADE NAME _____

SEG. STYLE/WIDTH _____

TOTAL CHARGES \$ _____

3. FRAMES DATE ORDERED _____ DATE DISPENSED _____

MFR. _____ FRAME NAME _____

PATIENT PAYMENT \$ _____

BALANCE DUE \$ _____

Each lens furnished is of a quality equal to the first quality lens series manufactured by American Optical, Bausch and Lomb, Orthogon, Tillyer or Univis, and meets or exceeds the Section Z80.1 or Z80.2 standards of the American National Standards Institute.

Yes No

Please type, print, or stamp in this space, you name & complete mailing address, including zip code.

I HEREBY CERTIFY THAT ALL THE OPTICAL SERVICES AND MATERIALS LISTED ABOVE WERE PURCHASED FROM ME IN ACCORDANCE WITH THE ABOVE REFERENCED PRESCRIPTION FOR THE ABOVE NAMED PATIENT.

SIGNATURE OF PROVIDER OF SERVICES OR MATERIAL _____

PROFESSIONAL DEGREE _____ DATE _____
 (M.D., O.D., OPTICIAN)

Telephone (Include area code)

Provider's Soc. Sec. No. or Emp's ID No.