JUSTIFICATION FOR REPLACEMENT OF EYEGLASSES

Spectrum Eyecare Optometry, Inc.
425 W. Bonita Ave., Suite 110B
San Dimas, CA 91773

South	**North**
909-394-0462	877-731-3222
Fax: 909-394-0014	Fax: 209-992-4100

www.SpectrumEyecareOptometry.com

DATE: _____ **FACILITY:** _____

TO: MEDI-CAL

RE: JUSTIFICATION FOR REPLACEMENT OF EYEGLASSES

To Whom It May Concern:

This is to certify, under penalty of perjury, that my eyeglasses were:

_____ Lost

_____ Stolen

_____ Broken (not repairable) notes: _____

Please describe the circumstances of the loss or destruction and the steps taken to recover lost eyewear: (glasses cannot be replaced without an explanation)

_____
_____
_____

_____ _____
Signature of Patient or Responsible Party **Print Patient Name**

_____ _____
Name of Responsible Party **Patient Date of Birth**

_____
Responsible Party Signature

CONSENT FOR EYE HEALTH AND VISION EVALUATION

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NOTE: Please make a choice about receiving these health care items or services.

We expect that your insurance will not pay for the item(s) or service(s) that are described below. Your insurance does not pay for all of your health care costs. Your insurance only pays for covered items and services when their rules are met. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, your insurance probably will not pay for the following items.

Please check the box(es) below for the services or products you would like:

☐ **Medicare Copayment for Eye Health Evaluation** (20% not covered by Medicare)	**(Cost: Approx. $25-35) ***
☐ **Private Pay Exam**	**(Cost: $110 new patient, $99 existing patient)**
☐ **Vision Plan Co-pay (Exam and/or Glasses)**	**(Cost: Dependent on Individual Plan)**

Non-Covered by Medicare:

☐ **Refraction Only (Check Vision in addition to Eye Health Evaluation):**	**(Cost: $68)**
☐ **Eyeglasses**	**(Cost: Approx. $129-149) ****
☐ **Low Vision Aid**	**(Cost: $_____)**

*** Individual fees may vary depending on specific insurance plan coverage.**
****Additional fees may apply for specialized lenses or other optional items.**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Ask us to explain, if you don't understand why your insurance probably won't pay.

.Please note that glasses will not be made until payment/copays is received.

☐ **YES:** I request to have the goods or services checked above provided by Spectrum Eyecare Optometry, Inc.
I agree to be responsible for any items checked above that are not covered by this insurance.

☐ **NO**: I do not request these goods or services at this time.

_____	_____	_____
Member Name	Facility Name	Date
_____	_____	_____
Responsible Party Signature	Responsible Party Name	Relationship to Member

Verbal Consent Received By: _____ on _____ from _____.

Notes: _____