



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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	R. EYE	SPHERE	CYLINDER	AXIS	PRISM	ADD	
	L. EYE						
THE PRESCRIBED LENSES ARE:						DATE OF PRESCRIPTION	PRESCRIPTION NUMBER
<input type="checkbox"/> Aphakic Lenses <input type="checkbox"/> Changed from Previous Lenses <input type="checkbox"/> Same Prescription as Previous Lenses							

CHARGES FOR EXAMINATION, LENSES AND FRAMES

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

2. LENSES DATE ORDERED _____ DATE DISPENSED _____

TOTAL EXAM CHARGE \$ _____

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 Unlvis, 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. _____