MUTUAL MEDICAL

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 / Spse. / 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 ☐

2. LENSES DATE ORDERED _____ DATE DISPENSED _____

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

MFR. _____ TRADE NAME _____

SEG. STYLE/WIDTH _____

3. FRAMES DATE ORDERED _____ DATE DISPENSED _____

MFR. _____ FRAME NAME _____

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

TOTAL EXAM CHARGE $ _____

TOTAL LENSES CHARGE $ _____

FRAME CHARGE $ _____

TOTAL CHARGES $ _____

PATIENT PAYMENT $ _____

BALANCE DUE $ _____

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

Telephone (Include area code)

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

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)