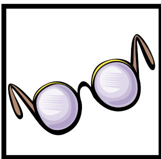

Maryland State Employees/Retirees

Vision Service Form

Administered by: MAMSI Health Plans

P. O. BOX 995 • FREDERICK, MD 21705-0995

SECTION 1 PATIENT INFORMATION

Patient's Member Number	Employee's Name (Last) (First) (M.I.)
Patient's Name (Last) (First) (M.I.)	Employee Address
Patient's Address if (Different than Employee's)	Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other Patient's Sex ☐ Male ☐ Female
	Telephone Numbers Home Work / Patient's Birthday

SECTION 2 HEALTH CARE PHYSICIAN/PRACTITIONER INFORMATION

Name (PLEASE PRINT) Tax ID Number ☐☐☐☐☐☐☐☐☐

Address Street City State Zip Code

Practitioner Must complete information below where applicable:

Line no.	Date of Service Mo Day Yr	PROC CODE	Description of Service (Available one a year)	Charges	Maximum Reimbursement Amount
1		Z7800	Exam (Vision Analysis)		$45.00
2		Z7801	Frames (Per Frame)		$45.00
3		Z7802	Lenses, Single Vision		$28.80
4		Z7803	Lenses, Bifocal Single		$48.60
5		Z7804	Lenses, Bifocal Double		$88.20
6		Z7805	Lenses, Trifocal		$70.20
7		Z7806	Lenses, Aphakic (Glass)		$54.00
8		Z7807	Lenses, Aphakic (Plastic)		$126.00
9		Z7808	Lenses, Aphakic (Aspheric)		$162.00
10		Z7809	Contact Lenses (Cosmetic)		$50.40
11		Z7810	Contact Lenses (Medically Required*)		$201.60

*Complete below if Contact Lenses are medically required:

Date of Cataract Surgery____________________________

Visual Acuity before___________after_________lenses.

Would glasses correct Visual Acuity to at least 20/70 in the better eye? ☐Yes ☐No

TOTAL CHARGES:___________

Practitioner Signature Date

SECTION 3 ASSIGNMENT OF BENEFITS (If signed, payment will be made directly to practitioner)

I hereby authorize payment directly to the provider of services. I understand that I am financially responsible to the provider for charges not covered by this assignment.

Signed____Date______________________________

SECTION 4 AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Subscriber, am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

Subscriber Signature_________________________Date__________Day Time Telephone________________

(Receipt must be attached for reimbursement)

Employee Address Correction

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Instructions

This Vision Service Form must be accompanied by a receipt if paid by the member. This form must be used by you to file a claim for reimbursement or, if your provider accepts Assignment of Benefits, to assign your benefits to the provider. NOTE: CLAIMS MUST BE SUBMITTED WITHIN ONE YEAR FROM DATE OF SERVICE. CLAIMS RECEIVED AFTER THAT PERIOD WILL BE DENIED. ADDITIONALLY, CLAIMS WILL BE DENIED IF MEMBER IS DETERMINED TO BE INELIGIBLE.

SECTION 1 PATIENT INFORMATION

This section contains information which identifies the individual who is eligible to receive services.

1. Complete each block.
2. Indicate the Member Number of the patient.
3. Complete employee information

SECTION 2 PROVIDER INFORMATION

The provider (eye doctor or optician) must complete this section.

1. Column 1: Enter the month/day/year that the service was provided.
2. Column 2: Enter amount charged for the service.
3. Complete the remaining Provider information requested (if applicable).
4. If you are to receive payment, the employee will sign the Assignment of Benefit section.
5. Be certain that all necessary patient and provider information has been completed. Submitting an incomplete form will result in a delay in processing.

SECTION 3 ASSIGNMENT OF BENEFITS (if applicable)

If signed, payment will be made directly to provider.

Member will be reimbursed only if acceptable proof of payment is submitted with claim. Acceptable proof of payment includes cancelled check or receipt from the provider of service.

SECTION 4 AUTHORIZATION

Your signature indicates agreement with the written authorization in this section and certifies that the services as described were received by you or your dependent. Indicate date signed and daytime telephone number.

Mailing Instructions (Employee/Provider):

Mail the completed service form and a copy of the receipt to:

MAMSI Health Plans
P.O. Box 995
Frederick, MD 21705-0995

Dedicated State of Maryland Member Services: 1-800-447-6267

Please allow 30 days for reimbursement