Office Policy

WE ARE IN NETWORK WITH THE FOLLOWING INSURANCE COMPANIES:

INSURANCE/COMPANY NAME	**BENEFIT**
BLUE CROSS BLUE SHIELD	**ROUTINE* AND MEDICAL VISITS**
VSP	**VISION EXAM AND MATERIALS**
COMMUNITY CARE	**VISION AND MEDICAL**
HUMANA	**MEDICAL**
HUMANA VISION CARE	**EXAM AND MATERIAL**
UNITED HEALTH CARE	**MEDICAL**
COMMUNITY CARE SR	**VISION EXAM AND MATERIALS**
HEALTHCHOICE	**MEDICAL VISITS ONLY**
MEDICAID/SOONERCARE	**ROUTINE AND MEDICAL VISITS**
MEDICARE	**MEDICAL ONLY**
PREFERRED COMMUNITY CHOICE	**ROUTINE* AND MEDICAL VISITS**
TRICARE STANDARD	**MEDICAL**
AARP	***MEDICAL***

****ROUTINE VISION BENEFITS NOT ON ALL PLANS-WE WILL VERIFY IF ANY BENEFITS ARE AVAILABLE WITH YOUR GROUP.***

WE WILL FILE ANY MEDICAL CLAIM FOR YOU IF YOUR PLAN ALLOWS US TO PROVIDE YOU WITH A MEDICAL SERVICE. (SOME PPO'S AND HMO'S WILL NOT COVER YOU IF YOU ARE OUT OF NETWORK-IT'S YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE AND YOUR NETWORK)

If you have insurance for vision care **or** for medical care, we need to know the name of your insurance company as well as any additional information necessary to file a claim. Many companies now require pre-approval or pre-authorization before eye care services are performed. ***If your insurance requires preauthorization and it is not requested prior to your eye care, the insurance company will not pay the bill and you will be responsible for the fees.***

1. Patients who carry Health Care Insurance should remember that professional services are rendered and charged to the patient and not to the Insurance Company.
2. Even though we will file your insurance claim, this office cannot accept responsibility for negotiating a settlement on a disputed claim. **You are ultimately responsible for the balance on your account should your insurance company deny your claim for any reason.**

ASSIGNMENT OF BENEFITS AUTHORIZATION

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the above information on this sheet and have provided the information requested if applicable on my insurance. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance or routine vision coverage. I request that payment of authorized medical or routine vision benefits be made to Mannford Vision Clinic on my behalf for any services furnished by Mannford Vision Clinic if applicable. I authorize Mannford Vision Clinic to release to the health plan indicated if applicable, any information needed to determine these benefits or benefits payable to related services.

Date_____ **Signature**_____