OUT-OF-NETWORK FORM

PATIENT INFORMATION

LAST NAME ____ FIRST NAME ____ MIDDLE INITIAL ____

ADDRESS ____ CITY ____ STATE ____ ZIP CODE ____

PHONE ____ DATE OF BIRTH ____ MEMBER ID ____

PROVIDER (DOCTOR) INFORMATION

DOCTOR'S NAME ____ PHONE ____

ADDRESS ____ CITY ____ STATE ____ ZIP CODE ____

PAYMENT REQUEST

SERVICES	$ EXAM	$ REFRACTION	$ DIALATION	$ CONTACT FITTING	$ OTHER
LENSES	$ SINGLE VISION	$ BIFOCAL	$ TRIFOCAL	$ PROGRESSIVE	$ OTHER
LENS OPTIONS	$ ANTI-REFLECTIVE	$ SCRATCH	$ POLYCARBONATE	$ TINT	$ OTHER

DATE OF SERVICE - ____ TOTAL AMOUNT PAID - $ ____

AUTHORIZATION

Patient or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this request for payment. By signing below, I acknowledge that the above information is true and correct.

SIGNED ____ DATE ____

Mail this Out-Of-Network payment request along with itemized receipts to:

Vision Care Direct
Out-of-Network Request
405 S Holland, Suite A
Wichita, KS 67209