

## INSURANCE REIMBURSEMENT INFORMATION

Primary Insurance Co. \_\_\_\_\_ Date of Service \_\_\_\_\_

Patient's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ SS#: \_\_\_\_\_ M/F  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Primary Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ SS#: \_\_\_\_\_ M/F  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Employer: \_\_\_\_\_

### EXAM INFORMATION

Comprehensive: \$105.00  
Refraction: \$20.00  
Tax (2%): \$2.50

### EYEWEAR INFORMATION

#### **Procedure Codes**

V2020 Frame  
92310 Contact Fitting

<u>New Pt.</u>	<u>Estab. Pt.</u>	<u>Type</u>
92004	92014	Comprehensive
92015	92015	Refraction

V2100	Single Vision
92341	SV Disp. Fee
V2200	FT 28 / Round Top
V2300	7 x 28 / Progressive
92342	Multi-focal Disp. Fee

### Diagnostic Codes

(Cat.) 366.9      (+) 367.0      (-) 367.1      (Astig.) 367.20      (Bi/Tri.) 367.4

I authorize the release of any information necessary to process this claim and payment to the party who accepts assignment. I am aware that if this is rejected by insurance due to ineligibility for services, I am liable for payment of this service and will receive a bill from Mankato Vision Center. If my credit card is on file, I authorize Mankato Vision Center to charge my credit card within 10 business days from the billing date.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_