

Brian J. Kane, O.D., Edw. S. Friedman, O.D, Stephen A.Figler, O.D., Todd M. Dalessandro, O.D.,
Anna Ellsesser, O.D.

Eye Care Authorization for _____

Complete eye care is available at home or a facility. Family Eyecare provides comprehensive eye care from glasses repair to medical care. The comprehensive exam includes evaluation for cataracts, glaucoma, macular degeneration, and various pathologies of the eye. Refraction for glasses and tests as needed. Materials available: contacts, eyeglasses, eyeglass chains and any optometric item requested will be available depending on supply..

To request an Eye Exam for your parent, relative or friend, please initial below all that applies. You MUST indicate the primary reason for the services requested and have a signed order from the attending Physician. Without a signed order from the physician for a medically necessary evaluation the POA will be financially responsible for routine services. Please note: loss of vision, eye pain, headache, flashes, floaters, red eyes, discharge or continuous care are examples of reasons for an eye exam. Medicare may cover up to 80% of covered fees. Medicaid (Ohio welfare) covers all eye exam fees and glasses if required except Disability and QMB of Medicaid. Secondary insurances we are contracted with can be submitted by FEC Mobile Eye Clinic if proper insurance information is provided. If glasses are required by residents without Medicaid the residents P.O.A. will be contacted by a FEC Mobile Eye Clinic representative to receive verbal authorization to order glasses. Glasses will not be delivered until payment is received in full. Please check one of the following that apply: _____ I, the resident or responsible party, hereby permit _____ TO BE EXAMINED AND TREATED by the optometrist. I authorize release of necessary medical information required for proper treatment and insurance billing.

Medical Reason for Service: _____ Must have a attending physician order written.

Services Requested: Medicare does not cover routine eye exams or refractions.

Comprehensive Eye Exam _____ Continuous Care for _____

Frames and Lenses (cost from \$134.00 and up) _____ Repair/Adjust eyeglasses

_____ NOTE: Family EyeCare will process all Medicare and Medicaid claims.

I, the resident or responsible party, understand that I am responsible for the unpaid fee for any approved eye care services including continuous care that will be rendered to me by FEC Mobile Eye Clinic staff. Also, if further eye care services are needed, of which I am responsible for the fee, they will not be rendered unless authorized by the responsible party. Also, in signing, I give permission to any primary or secondary insurance to release payment directly to FEC Mobile Eye Clinic and allow release of all pertinent information required to determine insurance coverage.

Primary Medical Insurance: _____ Policy #:

_____ Secondary Medical Insurance:

_____ Policy # _____ Vision

Insurance: _____ Policy# _____

I certify that I have read and agree to all of the above provided information, and that it is complete and true to the best of my knowledge.

POA Signature _____ Date _____

_____ I, the resident or responsible party, PREFER NOT TO UTILIZE the service of FEC Mobile Eye Clinic at this time. If available, please provide for the Long Term Care Facility, the eye doctor to whom you will arrange for transportation and who will render necessary eye care services, including emergency care.

Eye Doctor's Name _____ Phone #:
