***ABOUT YOUR INSURANCE….***

**Bettendorf Eyecare Center is a provider for many area Medical Insurances and Vision Plans. Listed below are some of the major plans in which we participate. \*\* Please look them over and circle the plan(s) that you will be using. *Most plans require that an ID card be presented prior to the examination to submit for reimbursement.***

* **BCBS –** *ID card is required.* Some plans have a co-payment due at the time of the exam. The portion not covered by insurance is the patient’s responsibility.

* **United Healthcare –** *ID card is required.* Some plans have a co-payment due at the time of the exam. The portion not covered by insurance is the patient’s responsibility.
* **UMR –** *ID card is required*. Some plans have a co-payment which is due at the time of the exam.
* **Unity Point/Health Partners –** *ID card is required*. Some plans have a co-payment which is due at the time of the exam.
* **Medicare** – *ID card is required.* Yearly deductible applies. **Refraction fee ($30.00) is not covered** and will be expected at the time of the exam. A portion of exam or office visit may be covered if there is a medical diagnosis. Please present your ID card(s) for any secondary/supplemental insurance to Medicare as well.

* **Avesis** – *ID card is required*. Some plans have a co-payment that is due at the time of the exam. Each Avesis plan varies as to coverage. Knowledge of eligibilityfor service or materials is your responsibility. Co-payments are expected at the time of the exam.

* **EyeMed –** *ID card is required.* Each EyeMed plan varies as to coverage. Knowledge of eligibilityfor service or materials is your responsibility. Co-payments are expected at the time of the exam.

* **Davis Vision** – *ID card is required.* Some plans have a co-payment which is due at thecompletion of the exam. Each Davis Vision plan varies as to coverage. Knowledge of eligibilityfor service or materials is your responsibility. Glasses are required to be sent to a Davis laboratory and may take slightly longer than usual.
* **Superior Vision –** *ID card is required.* Each Superior Vision plan varies as to coverage. Knowledge of eligibility for service or materials is the patient’s responsibility. Co-payments are expected the day of service.

* **Spectera (United Healthcare Vision) –** *ID card is required.* Each Superior Vision plan varies as to coverage. Knowledge of eligibility for service or materials is the patient’s responsibility. Co-payments are expected the day of service.

* **VSP (Vision Service Plan)** –Each VSP plan varies as to coverage. Knowledge of eligibility for service or materials is the patient’s responsibility. Some plans have a co-payment for the exam and/or eye glasses or contact lenses. Glasses are required to be sent to a VSP laboratory and may take slightly longer than usual. **Please be aware that we will ask for the Social Security number of the insured person so that we may retrieve current benefits for you**.

**I have medical and or vision insurance and I understand that not all services are included with my insurance plan and anything that is not covered or included in my plan will be my responsibility to pay.**

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YOU DO NOT HAVE INSURANCE OR DO NOT HAVE ONE THAT IS LISTED PLEASE CONTINUE:**

I have medical/vision coverage other than those listed above. Please specify below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If I do not have a medical/vision insurance plan that Bettendorf Eyecare Center participates in I understand that payment is my responsibility. Payment is expected the day of service. \*\*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**\* All Co Pay whether Medical or Vision will be expected at the time of the exam.**

**\*\* For those insurance plans that we are not preferred providers, payment is due at the completion of the service. We will be happy to supply you with the necessary paperwork that you may submit yourself for possible direct reimbursement from your plan.**