PROVIDER STATEMENT

SERVICES: EXAMINATION

Patient Name ______________________ Diagnosis Code: ____________

Date of Exam: ______________________ FEE: $ ____________
MO. DAY YR.

Date	Provider's Name (print)	Degree		Individual Practitioner's SS #
Street Address	City or Town	State or Province	Zip Code	All Others – Employee I.D. #
Provider's Signature		Telephone		

PROVIDER STATEMENT

SUPPLIES: FRAMES/LENSES

FRAMES: Date Ordered ______________________
MO. DAY YR.

Date Dispensed ______________________
MO. DAY YR.

FRAMES: New ☐ Service to old frames ☐

TOTAL FRAME CHARGE $____________

LENSES: Date Ordered ______________________
MO. DAY YR.

Change in prescription? ☐ yes ☐ no

Date Dispensed ______________________
MO. DAY YR.

TYPE:

- ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Lenticular ______________________ $____________
- ☐ Contact Lenses ☐ Soft ☐ Hard ☐ Gas Permeable ______________________ ____________
- ☐ Oversized Lenses ______________________ ____________
- ☐ Sunglasses ______________________ ____________
- ☐ Tint # ______________________ ____________
- ☐ Photosensitive – i.e. Brown, Gray, etc. ______________________ ____________
- ☐ Other (explain) ______________________ ____________

TOTAL LENS CHARGE $____________

TOTAL CHARGES $____________

Date	Provider's Name (print)	Degree		Individual Practitioner's SS #
Street Address	City or Town	State or Province	Zip Code	All Others – Employee I.D. #
Provider's Signature		Telephone		