# Medical Contact Lenses

Patient Name: _______________________________________________DOB: _________________________

Parent/Guardian Name: ______________________________

DOS: _______________ MRN #:____________ Physician Name: __________________________________

Contact lenses may be considered medically necessary by your medical insurance carrier. This may occur in a specific case when correction with glasses does not offer adequate vision. Your insurance company will determine if these materials and/or services are a covered benefit within your plan.

By signing below, you understand that you are responsible for payment of materials and /or services that may be declined by your insurance company.

Patient/Parent Signature: ___________________________________________ Date: ___________________

Staff Signature: ___________________________________________________ Date: ___________________