ULTRA-VISION

MEMBER________________________________ SOCIAL SECURITY NO.______________

ADDRESS______________________ ______________________ ______________________
Street City State & ZIP Code

SCHOOL DISTRICT OR GROUP__________________ DOES YOUR SPOUSE HAVE A SEPARATE POLICY WITH SET? _____YES _____NO

NAME OF PATIENT:____________________ **BIRTHDATE:**__________ **RELATIONSHIP:**______________

ITEMIZED STATEMENT OF SERVICES

DATE OF SERVICE(S):__________________

EXAMINATION:		**LENSES:**		**CONTACTS:**	
EXAM	$	SINGLE VISION	$	HARD LENSES	$
REFRACTION	$	BIFOCAL	$	SOFT LENSES	$
VISION ANALYSIS	$	TRIFOCAL	$	DISPOSABLE	$
OTHER	$	PROGRESSIVE	$	SOLUTIONS	$
OTHER	$	PHOTOGRAY	$	KIT/HEATER	$
		TINT	$	OTHER	$
FRAMES:	$	OVERSIZE	$	OTHER	$
OTHER	$	OTHER	$	**GRAND TOTAL**	**$**

PROVIDER INFORMATION:

NAME__________________________ TIN#______________ TELEPHONE NO.______________

ADDRESS______________________ ______________________ ______________________
Street City State & ZIP Code

TO BE COMPLETED BY THE EMPLOYEE:
I authorize payment of vision benefits to the physician or supplier described above.

SIGNATURE________________________________ DATE ______________

This is an itemized Statement only and is not intended to identify covered charges.

MAIL TO:
SET-SEG
415 W. KALAMAZOO ST.
LANSING, MI 48933
ATTN: VISION CLAIMS

TOLL-FREE: 1-800-292-5421
LOCAL: 1-517-482-0871

FORM NO. 410 (10-99)