

Patient's Name: _____

Patient's Health #: _____

<input type="checkbox"/> Exam <input type="checkbox"/> Dilation	<input type="checkbox"/> Lens Exception (reason – with Opt. signed letter) <input type="radio"/> Left eye <input type="radio"/> Right eye
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Service Date :	Service Description :	Cost of Service :	Insurance Plan :
	<input type="checkbox"/> EXAM	\$116.40	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> DILATION	\$45.00	<input type="checkbox"/> Yes <input type="checkbox"/> No
	TOTAL COST of PRE-APPROVAL	\$161.40	

<p>Pharmacare Program <u>WILL COVER</u> :</p> <input type="checkbox"/> EXAM - basic every 2 years <input type="checkbox"/> FRAMES - \$100 every 2 years <input type="checkbox"/> LENSES - Prescription only every 2 years <input type="checkbox"/> EXCEPTION LENS - 1 per eye following cataract surgery <i>(letter from Optometrist required for authorization)</i>	<p>Pharmacare Program does <u>NOT COVER</u> :</p> <input checked="" type="checkbox"/> NO Tinting or Coating or Featherweight <input checked="" type="checkbox"/> NO Repairs to Eye Glasses <input checked="" type="checkbox"/> NO 2 nd pair of Glasses or Sunglasses <input checked="" type="checkbox"/> NO Contact Lens Exam or Contact Lenses <input checked="" type="checkbox"/> NO Shipping & Handling
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Whitehorse Optometrist Inc.

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Patient's Signature: _____ Date: _____

Patient will sign at exam

Dr. Brett Bartelen and Dr. Jared Zeeben

NAME OF APPLICANT (PRINTED)

WHITEHORSE



OPTOMETRIST

Program Office Use Only

Optometrist

PROFESSION

Approved: _____ Date: _____	Declined: _____ Date: _____ Reason: _____
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