OFFICE POLICY

We are in network with the following insurance companies:

Blue Cross Blue Shield	VSP
Community Care	Humana
Humana Vision Care	United Health Care
Health Choice	SoonerCare
Medicare	Preferred Community Choice
Tricare Standard	AARP

*ROUTINE VISION BENEFITS NOT ON ALL PLANS WE WILL TRY TO VERIFY IF ANY BENEFITS ARE AVAILABLE ON YOUR PLAN.

WE WILL FILE ANY MEDICAL CLAIM FOR YOU IF YOUR PLAN ALLOWS US TO PROVIDE YOU WITH A MEDICAL SERVICE. (SOME PPO'S AND HMO'S WILL NOT COVER YOU IF YOU ARE OUT OF NETWORK. IT'S YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE AND YOUR NETWORK.)

If you have insurance for vision care or for medical care, we need to know the name of your insurance company as well as any additional information necessary to file a claim. Many companies now require pre-approval or pre-authorization before eye care services are performed. **If your insurance requires pre-approval and it is not requested prior to your eye care, the insurance company will not pay the bill and you will be responsible for the fees.**

1. Patients who carry health care insurance should remember that professional services are rendered and charged to the patient and not the to the insurance company.
2. Even though we will file your insurance claim, this office cannot accept responsibility for negotiating a settlement on a dispute claim. You are ultimately responsible for the balance on your account should your insurance company deny your claim for any reason.

Assignment of Benefits Authorization

I understand and agree that (regardless of my insurance status): **I am ultimately responsible for the balance on my account for any professional services rendered.** I have read all of the above information on this sheet and have provided the information requested if applicable on my insurance. I certify this information is true and correct to the best of my knowledge. I will notify Mannford Vision in my health insurance or routine vision coverage. I request that payment of authorized medical or routine benefits be made to Mannford Vision Clinic on my behalf for any services furnished. I authorize Mannford Vision Clinic to release to the health plan indicated if applicable, any information needed to determine these benefits or benefits payable to the related services.

Date:_____Signature:_____

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