Vision Insurance Benefit Verification Checklist

When calling your insurance provider, use this guide to help ensure you receive the information you need to determine what your vision benefits are.

Personal and Insurance Details

Full Name: _____ Date of Birth _____

Insurance Plan Name: _____ Insurance ID#: _____

Group #: _____

Clinic Name: Lakeview Clinic Address: 424 Highway 5 W, Waconia, MN 55387

Tax ID: 411340895 NPI: 1669599981

Provider Name: Dr. Bradley Ludwig, OD Dr. Tracy Jackson, OD Dr. Thomas Bryan OD

Routine Vision Care Questions - (refer to Medical Vision section if diabetic)

Do I have routine vision benefits under my current plan? YES NO

Is Lakeview Clinic or the selected provider IN-NETWORK for my vision benefits? YES NO

IF NO, how much will I be reimbursed for an out-of-network exam? $_____

What services are covered under routine vision care? (eye exams, glasses, contacts)

Are there copays, deductibles, or specific coverage details I should be aware of? YES NO

Details:

Do I need a referral or prior authorization for vision services?

How often can I get an eye exam or new glasses/contacts?

Medical Vision Care Questions

Do I have medical vision benefits under my current plan? YES NO

(e.g., Diabetic Eye Exams, Glaucoma, Cataracts, Macular Degeneration, Eye Infections, Hypertension Eye Exam)

Is there coverage for emergency eye care or injury treatment? YES NO

Is Lakeview Clinic or the selected provider IN-NETWORK for my **medical** vision benefits?

YES NO

Are there copays, deductibles, or specific coverage details I should be aware of? YES NO

Details:

Call Documentation:

Representative Name: _____ Date/Time of Call: _____

Reference Number: _____

RETAIN THIS DOCUMENT & BRING IT TO YOUR APPOINTMENT