An Independent Licensee of the Blue Cross and Blue Shield Association

FORMS – Miscellaneous Forms

Vision Patient Certification Statement

HMSA'S PLAN FOR QUEST MEMBERS

VISION PATIENT CERTIFICATION STATEMENT

EYEGLASSES/CONTACTS

I did not receive a pair of prescription eyeglasses or contact lenses within the last 24 months.

_____ _____
Signature Date

_____
Name (please print)

EXAM

I did not have an eye examination (refraction) within the last 24 months. (12 months for children age 20 or younger).

_____ _____
Signature Date

_____
Name (please print)