

PROVIDER UTILIZATION REPORT

Patient Name: _____

Primary Member's Name (if different): _____

VPA Group\Member#: _____ Date of Service: _____

Services Provided - Circle applicable:

Eye Exam	Lenses	Frames	Contact Lenses	Aphakic
	S/V			OD OS
	B/F			
	T/F			
	Other			

If other, please explain: _____

Does patient have any Eye Medical condition that does not require referral: **YES NO**
(If Yes what is the Diagnosis)

Diagnosis: _____

Medical Referral (if applicable) to:

Dr. _____

Telephone: _____

Provider Name: _____ Fac#: _____

Address: _____

_____ Telephone: _____

Date: _____ Member's Signature: _____

** Provider we welcome your comments: _____

PLEASE RETURN TO VPA IMMEDIATELY AFTER SERVICE

Please fold in half, staple and mail, or fax to (213) 384-0084,
or at www.visionplanofamerica.com complete and send.

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