GREENSPAN FAMILY EYECARE

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►VERIFICATION OF BENEFITS OR COVERAGE *IS NOT* A GUARANTEE OF ELIGIBILITY OR *PAYMENT*. ACTUAL PAYMENT IS BASED ON TERMS AND CONDITIONS OF YOUR PLAN AT TIME OF INSURANCE PROCESSING.◄
*** AS A COURTESY WE WILL *TRY* TO CONTACT *YOUR* INSURANCE COMPANY FOR ELIGIBILITY STATUS. IT IS *YOUR* RESPONSIBILITY TO MAKE SURE *YOU* HAVE COVERAGE FOR THE DATE OF SERVICE THROUGH *YOUR* INSURANCE***

SIGNATURE ON FILE

- ✓ I authorize use of this form on *all* my insurance submissions.
- ✓ I authorize release of information to all my insurance companies.
- ✓ I understand that *I am responsible* for any balance after insurance processing.
- ✓ I authorize my doctor to act as my agent in helping me obtain payment from the insurance company.
- ✓ I authorize payment to be made directly to above mentioned doctors and/or practice.
- ✓ I permit a copy of this authorization to be used in place of the original.

THERE IS A FEE FOR CONTACT LENS FITTING OR EVALUATION OF YOUR CURRENT CONTACT LENSES WHICH MAY OR MAY NOT BE COVERED BY INSURANCE.

Signature_____

Name (print)_____

Date_____