Muirfield Eye Care

6105 Memorial Drive Dublin, OH 43017 Phone (614) 793-8440 Fax (614) 793-8383
www.muirfieldeyecare.com

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Muirfield Eye Care Center can file both medical and vision claims. Please provide us with **complete information** below. Also provide your photo ID and any medical and/or vision cards you have to our staff so they may keep a copy on file with your records.

Vision Insurance Plan? Yes / No

Name of Plan: _____

Primary Member: _____ ID#: _____

Member's Date of Birth: _____

Patient's Relationship to Member: ____Self ____Spouse ____Domestic Partner ____Child ____ Other

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Medical Insurance Plan? Yes / No

Name of Plan: _____

Primary Member: _____ ID#: _____

Member's Date of Birth: _____

Patient's Relationship to Member: ____Self ____Spouse ____Domestic Partner ____Child ____ Other

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Secondary Medical or Vision Insurance Plan? Yes / No

Name of Plan:_____

Primary Member: _____ ID#: _____

Member's Date of Birth: _____

Patient's Relationship to Member: ____Self ____Spouse ____Domestic Partner ____Child ____ Other

Individuals with whom we may share the above information (spouse, children, parents, caregivers, etc.)

Name: _____ Phone: _____ Relationship:_____

Name: _____ Phone: _____ Relationship:_____

Insurance coverage and terms are the patient's responsibility. Muirfield Eye Care Center tries to authorize each patient's vision insurance prior to their appointment. We do attempt to notify you in advance if we foresee any issues with your insurance. Please remember, your insurance contract is between you and the insurance carrier. It is possible that insurance may cover only part of the charges. If we do not accept direct payment from your insurance plan, you will be billed up-front and provided with a paid receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with any question on your claims.
Your signature below signifies you understand this statement and give the office of Muirfield Eye Care Center permission to authorize and file insurance claims on your behalf.

_____ _____ _____

Signature of Patient, Parent, Guardian, or Representative | Print Name | Date