



*Evelyn Marie Moore, O.D.*  
501 S. Mattis Avenue  
Champaign, Illinois 61821

**Vision Insurance**  
(Covers Eyewear and/or Contact Lenses)

Name of Insurance: VSP EyeMed Other \_\_\_\_\_

ID# (include all Letters and suffixes) \_\_\_\_\_ Group Plan# \_\_\_\_\_

Subscriber is:  Patient  Guarantor  Other Relationship to Patient \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's Social Security # XXX-XX-\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
*(If different from Responsible Party)*

Employer \_\_\_\_\_ Employer's Telephone ( ) \_\_\_\_\_

**Primary Medical Insurance**  
(Covers Eye Health Examinations when there is a medical condition)

Name of Insurance: \_\_\_\_\_

ID# (include all Letters and suffixes) \_\_\_\_\_ Group Plan# \_\_\_\_\_

Subscriber is:  Patient  Guarantor  Other Relationship to Patient \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's Social Security # XXX-XX-\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
*(If different from Responsible Party)*

Employer \_\_\_\_\_ Employer's Telephone ( ) \_\_\_\_\_

**Secondary (or Supplemental) Medical Insurance**

Name of Insurance: \_\_\_\_\_

ID# (include all Letters and suffixes) \_\_\_\_\_ Group Plan# \_\_\_\_\_

Subscriber is:  Patient  Guarantor  Other Relationship to Patient \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's Social Security # XXX-XX-\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
*(If different from Responsible Party)*

Employer \_\_\_\_\_ Employer's Telephone ( ) \_\_\_\_\_

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIAN: I authorize the release to the Centers for Medicare and Medicaid Services (CMS) and its agents or other third party insurers of any medical or other information necessary to process any claims and I authorize payment of medical, government or Medicare benefits to Evelyn Marie Moore, O.D., P.C. for services rendered. It is understood that Evelyn Marie Moore, O.D., P.C. may file insurance claims as a courtesy, however, Evelyn Marie Moore, O.D., P.C. does not accept responsibility for collecting insurance benefits or negotiating the settlement of a disputed claim. The Undersigned is/ or responsible for payment of all charges regardless of anticipated insurance coverage.

Signature of Patient (Parent or Guardian if Patient is under 18 years of age) \_\_\_\_\_ Date \_\_\_\_\_