REQUEST FOR PARTICIPATION IN THE VISION SERVICE PROGRAM

EFFECTIVE DATE OF PROGRAM PARTICIPATION:

OFFERED BY: Sterling Health Services LLC in association with Sterling VAS, LLC
COMPLETED REQUEST TO BE RETURNED TO: Sterling Health Services, LLC, PO Box 891330, Oklahoma City, OK 73189-1330
Tel (405) 728-1278 Fax: 405-720-2441 Toll Free Fax: (866) 346-6851

PROPOSED PROGRAM PARTICIPANT-Individual Receiving Vision Care		
NAME (Please Print) (Last, First, M.I.)	☐ Male ☐ Female	Date of Birth _____/_____/_____
Social Security Number	Medicaid Number	

APPLICANT RESPONSIBLE PERSON-If other than Proposed Participant if signing on behalf of the Proposed Participant			
Name	Relationship		
Address	City	State	Zip

FACILITY WHERE PROPOSED PARTICIPANT RESIDES			
Name	Phone:		
Address	City	State	Zip

SIGNATURE FOR RELEASE OF MEDICAL INFORMATION AND CONSENT TO TREATMENT

- I understand that participation in this program will not be approved until this request and applicable payment (if required) has been received, accepted, and evidence of authorization has been forwarded to the participant or the responsible person.
- I understand that this IS NOT AN INSURANCE POLICY but a VALUE ADDED SERVICE offered by Sterling Health Services LLC on behalf of Sterling VAS LLC. This is not a Contract nor does it guarantee any service or reimbursement for loss or damage.
- I hereby authorize the Service Provider or designated staff of the Service Provider (Optometry services) hereinafter referred to individually or collectively as "Provider", to examine and recommend treatment and perform certain procedures on the patient when, in the professional opinion of the Provider, these services are necessary.
- Upon such diagnosis, I understand that if treatment that is not covered by Medicare, Medicaid, or other insurance, such treatment will be provided only upon my verbal or written authorization.
- I hereby assign all insurance benefits (if any) to Service Provider for treatment and care rendered to the patient by Service Provider. The assignment includes benefits payable by Medicare, Medicaid, Medigap and all other insurance programs of which the patient is a beneficiary.
- HIPAA COMPLIANT: Service Provider agrees to be compliant with the Health Insurance Portability and Accountability Act of 1996, "HIPAA." Service Provider agrees to maintain the confidentiality of individually identifiable health information of the patient in accordance with HIPAA. Notwithstanding the above, I authorize the release of all medical and non-medical information concerning the patient from and to all sources necessary for the purposes of continuing treatment and securing payment from insurance, or other payees, for services rendered by Service Provider. I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization.

PROPOSED PLAN PARTICIPANT RESPONSIBLE PERSON SIGNATURE:_____ DATE: _____

*****OFFICE USE ONLY *****

Signature of Approval _____ Date_____