Arizona Eye
SPECIALISTS

NOTICE OF NON-COVERED SERVICES

CONTACT LENS SERVICES

Patient Name _____ Date of Birth _____

In order to provide the best contact lenses for you, it is necessary for your doctor to perform a **Refraction** exam (test to determine the prescription for glasses) and a **Contact Lens Evaluation/Fit**. These services are separate from your eye exam. They are considered routine vision and are not covered by most medical insurances. Coverage by vision insurance for these services varies according to your plan. You are responsible for any non-covered amount as well as any co-pays, deductibles or co-insurance.

We will make every effort to determine your vision plan benefits for you, or you may contact your insurance for benefit information

(**CPT Codes**: 92310-Contact Lens Evaluation, 92015–Refraction, 92072–Medically Necessary Evaluation/Fit).

Refraction Fee	**$50.**	**RGP Evaluation/Fit**	**$125**
Yearly Contact Lens Evaluation	**$50**	**RGP Toric Evaluation/Fit**	**$150**
Soft Contact Evaluation/Fit	**$75**	**RGP Mono Evaluation/Fit**	**$150**
Soft Toric Evaluation/Fit	**$100**	**RGP Bifocal Evaluation/Fit**	**$175**
Soft Mono Evaluation/Fit	**$125**	**Medically Necessary Evaluation/Fit - $250 - $500**	
Soft Bifocal Evaluation/Fit	**$150**		

____Yes, I want the Refraction & Contact Lens Evaluation/Fitting. **I understand my Insurance may not cover these services and I am responsible for the fees at the time of service.**

Signed _____ Date _____

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