United Health Vision/Spectera – Authorization form

Policy Holders Name: _____
_____
LAST NAME FIRST NAME

Policy Holders Date of Birth: _____/____/_____
MONTH DAY YEAR

Policy Holders Social Security # _____ - _____ - _____

Patients Name: _____
_____
LAST NAME FIRST NAME

Patients Date of Birth: _____/_____/_____
MONTH DAY YEAR

Date of Examination: _____

Print name: _____

Authorized Signature: _____

OFFICE USE ONLY

Plan Code: _____

Claim Authorization # _____

EXAM FEE: _____

Co-Pay $ _____ *BILLED AMOUNT:* _____

CPT: _____ _____ _____

ICD9: _____ _____ _____