



## DELTA VISION PATIENT ENCOUNTER FORM

Please complete all necessary information. Any encounter form with missing information (such as eye identifier, enrollee's ID number, etc.) will be sent back to your office for completion.

1. Refer to the eligibility list to complete the top portion of the form.
2. List all procedures or services (exam, frames, lenses, tints, etc.) initiated and/or completed at a given visit on one form by:
  - a. Finding the applicable listed service on the form.  
*If a service is not listed, you may enter the code and description in the blank field in the lower right corner of the form.*
  - b. Indicating the eye(s) for which the lens or other service was provided by circling "L" for the left eye; "R" for the right eye; or "L" and "R" for both eyes. Indicating the eye treated is not applicable or necessary for some listed vision services.
  - c. Entering the number of "Units" dispensed or provided under that column.
  - d. Listing any applicable charges to the patient, including non-covered services.

**Example:** If, after a comprehensive new patient examination, the patient receives new spectacles with:

- Standard frames at no cost;
- Single vision lenses for both eyes (left eye, spherocylinder lens +4.25D sphere and +4.00D cylinder; right eye, spherocylinder +6.00D sphere and +6.00D cylinder) at no cost; and
- The lenses are polycarbonate, which have copayments of \$25 per lens.

Then, the provider's encounter form should show the following under:

**"Routine Examination"**

Srvs Units	Proc Code	Description Srvs	Eye		Mbr Chrg
			L	R	
1	92004	Comp exam, New patient	X	X	\$0

**"FRAMES"**

1	V2020	Frames, original purchase	X	X	\$0
---	-------	---------------------------	---	---	-----

**"SV spherocylinder, plano to +/- 4.00D sphere"**

2	V2105	4.25 to 6.00D cylinder	X	X	\$0
---	-------	------------------------	---	---	-----

**"Polycarbonate & High Index (with lens code)"**

2	V2784	Polycarbonate-additional	X	X	\$50
---	-------	--------------------------	---	---	------

3. Submit completed forms to DeltaVision no later than the first week of the month following treatment.
4. Please do not fold each individual form when mailing.
5. Mail all completed forms directly to:

**Encounter Processing & Provider Compensation /PC740  
P.O. Box 1810  
Alpharetta, GA 30023**