Health PEI

Primary Care and Chronic Disease Prevention

PEI Eye See Eye Learn Program

Application for Co-Pay Reimbursement

Vision Care Programs
199 Grafton Street
Suite 208, Polyclinic
Charlottetown, PE C1A 1L2
Telephone: (902) 213-2970

www.healthpei.ca/eyesee-eyelearn

Optometrist, Please Complete the Following:
Name:
License Number:
Name of Client:
Date of Vision Assessment:

_____
Signature of Optometrist

ALL INFORMATION MUST BE COMPLETED OR FORM WILL BE RETURNED

Applicant Contact Information ***(Please see reverse side for instructions to complete form)***

Name of Parent/Legal Guardian:
Address:

Phone Contact: Home ( ) Work ( ) Cell ( )
E-Mail Address:

May we contact you by e-mail if necessary: o yes o no

Service & Payment Details

Name of Child Receiving Vision Assessment:
Date of Vision Assessment: Date of Birth:

PreKindergarten ☐ Kindergarten☐

PEI Health Number:

Name of Insurer: Total Invoice Amount:

Insurance Plan Number:

Amount Covered by Insurance Provider:

Co-pay Incurred by Parent/Guardian:

Amount Requested for Reimbursement:

Please note, by signing below you certify (Please review and check all):

- o ***The information being provided for this reimbursement request is accurate and true.***
- o ***I have attached a copy of the insurance claim statement.***
- o ***I have personally paid the co-pay cost incurred.***
- o ***I have attached a copy of the receipt(s) which show proof of paid co-payment for services provided.***
- o ***I consent to verification of this information.***
- o ***I understand that it is offence to give false information in this application.***

Signature: _____ Date: _____

Privacy Statement

The *Freedom of Information and Protection of Privacy (FOIPP) Act* of Prince Edward Island governs the collection, use and disclosure of personal information contained in this form.

If you have any questions about the collection, use or disclosure of your personal information, please contact the Health PEI Privacy and Information Access Coordinator at (902) 368-4942.

INSTRUCTIONS TO COMPLETE FORM

1) Ensure that the Optometrist has completed and signed the upper right corner for verification of the exam.

2) Complete the contact information with requested information.

3) Complete the service and payment details requested.

4) Carefully read and check the statement boxes to certify information is accurate and correct.

5) Attach your receipt and any evidence of insurance reimbursement made directly to you.

6) Send the completed and signed form to:
EyeSeeEyeLearn@ihis.org

7) If you have any questions, we are happy to help you. Please call us at (902) 213-2970