McLaren HEALTH PLAN

Vision Eligibility Request Form

Fax to: (833) 540-8648

PROVIDER NAME:		**DATE:**	
OFFICE CONTACT:		**TAX ID:**	
PHONE:		**NPI:**	
FAX:			

ELIGIBLE FOR*:

APPOINTMENT DATE	MEMBER NAME	MEMBER ID	DOB	EXAM	FRAMES	LENSES	COMMENTS

MHP STAFF INITIALS: _____ **DATE:** _____

Please call MHP Customer Service at (888) 327-0671 with questions.

** MHP will complete this section of form and fax back to the provider office.*

Please allow up to 48 business hours for a return response.