PATIENT LIABILITY FORM

Date: _____

I, _____, the undersigned, acknowledge that I have been informed that the procedure / service below falls outside of my COMMED Optical benefit, and I accept that I will be personally responsible for the cost thereof.

PATIENT NAME	
MEMBERSHIP NUMBER	
PRACTICE NAME	
PRACTICE NUMBER	
DATE OF SERVICE	
DETAILS OF ADDITIONAL LENS AND / OR FRAME ENHANCEMENTS	
TOTAL COST LIABILITY	

Signed

_____ _____

MEMBER **PROVIDER**