FLORIDA EYE INSTITUTE

Life is Looking Better Already

PATIENT INSURANCE BENEFIT ESTIMATE

NAME: _____ ACCT#: _____

PA BENEFITS

Cost of Surgery $ _____

$ _____

Patient Responsibility $ _____

Estimated* $ _____

Per Eye ☐ Both Eyes ☐

Omidria: _____

DSAEK: _____

Bio Tissue: _____

Referral YES ☐ NO ☐

Authorization YES ☐ NO ☐

FAC BENEFITS

Cost of Surgery $ _____

$ _____

Patient Responsibility $ _____

Estimated* $ _____

Per Eye ☐ Both Eyes ☐

Referral YES ☐ NO ☐

Authorization YES ☐ NO ☐

***** The above is an **ESTIMATE** of your out of pocket costs for physician and surgery facility fees. Patients are responsible for all copays and deductibles based on **PATIENT INSURANCE BENEFITS** in effect on the date services are rendered.

** Anesthesia will be billed separately.

Patient Signature: _____ Date: _____

Benefits Completed by: _____ Date: _____

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