



*Required Fields

Prescription Eyewear Order Form

Hi-Tech Optical, Inc.
 3139 Christy Way South
 Saginaw MI 48603
 (P) 800.638.1171 (F) 800.806.1663
www.hi-techoptical.com

Bill To:

Order Date
(MM/DD/YY)

Eligibility #

*Employee
Last Name

*Employee
First Name

Employee #

Employee
Phone

Bill-To: Account #: **2838**
 PLANT Employees

Acument – Belvidere Operations
 826 East Madison St
 Belvidere, IL 61008
 Rhonda Engelkes 815-544-0331

Ship-To: (Circle Provider)
#434 **#439**
 6410 E. State St 304 N. State St
 Rockford, IL Belvidere, IL
 815-397-2020 815-544-3431

Frame Groups	Co-Pay Amount
1. Standard/Baseline.....	00.00
2. Premiere.....	00.00
3. Trendsetter.....	20.00
4. Exclusive.....	30.00
5. Titanium.....	45.00

Lens Style	Co-Pay Amount
Single Vision.....	00.00
Bi-Focal.....	00.00
Tri-Focal.....	00.00
Progressive (Standard).....	00.00

Lens Material	Co-Pay Amount
Polycarbonate.....	00.00
Plastic.....	00.00
Glass.....	00.00

Lenses Only Complete Pair Patient's Own Frame Frame Only

Frame Style	Eye	Bridge	Color	Temple

Polycarbonate Plastic CR-39 Glass

Side Shields: Permanent

Single Vision Tri-Focal 28 35
 Bi-Focal 28 35 Progressive

CLEAR POLYCARBONATE LENSES WILL BE SUPPLIED IF NOT SPECIFIED

Clear
 Other _____

Prescription		Sphere	Cylinder	Axis	Prism	Base
	Right OD					
	Left OS					
		Add Power	Seg. Height	Distance PD	Near PD	
	Right OD					
Left OS						

Lens Options	Co-Pay Amount

Tints & Coatings	Co-Pay Amount

Other Options	Co-Pay Amount

Side Shields	Co-Pay Amount
Permanent	00.00

The employees are responsible for any upgrades. **ALL CREDIT CARD CHARGES ARE MADE BY HTO.**

*Signature is required for Emp Credit Card charges.

Card Type: VI, MC, AX, DI	Credit Card Number (xxxx-xxxx-xxxx-xxxx)	Expiration Date (MM/YY)	CVV	Total Amount

Dispensing	Co-Pay Amount
Dispensing Fee.....	00.00

Total \$ _____

Signature:

Doctor/Optician:
 Phone _____ Fax _____
 Signature _____

Supervisor Contact
 Phone _____
 Signature _____