Hi-Tech Optical

*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: 2315

Order Date (MM/DD/YY)

*Employee Last Name

*Employee First Name

Employee #

Employee Phone

Bill-To: Account #: 2315
Cox Communication
9 JP Murphy Highway
West Warwick, RI 02893
Ted Merriman 401-615-1186

Ship-To:
Provider #: 881
Total Vision Eyecare Center
362 Middle Turnpike West
Manchester, CT 06040
Jeanne 860-649-3311

☐ Lenses Only ☐ Complete Pair ☐ Patient's Own Frame ☐ Frame Only

Frame Style	Eye	Bridge	Color	Temple

☐ Polycarbonate ☐ Hi-Index

Side Shields: ☐ Permanent ☐ Detachable

☐ Single Vision ☐ Tri-Focal ◯28 ◯35
☐ Bi-Focal ◯28 ◯35 ☐ Progressive _____

CLEAR POLYCARBONATE LENSES WILL BE SUPPLIED IF NOT SPECIFIED

☐ Clear ☐ Premium Scratch Coating
☐ Transitions ☐ Standard AR Coating ☐ Other_____

Prescription

	Sphere	Cylinder	Axis	Prism	Base
Right OD					
Left OS					

	Add Power	Seg. Height	Distance PD	Near PD
Right OD				
Left OS				

The employees are responsible for any co-pay charges. **ALL CREDIT CARD CHARGES ARE MADE BY HTO.**
Signature is required for Employee Credit Card charges

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

Signature:

Doctor/Optician:
Phone_____ Fax _____
Signature _____

Frame Groups — Co-Pay Amount

1. Standard/Baseline.....00.00
2. Premiere.....00.00
3. Trendsetter.....00.00
4. Exclusive.....7.50
5. Titanium.....33.00

Lens Style — Co-Pay Amount

Single Vision.....00.00
Bi-Focal.....00.00
Tri-Focal.....00.00
Progressive (Standard).....00.00
Progressive (Premium).....40.00

Lens Material — Co-Pay Amount

Polycarbonate (SV/MF).....00.00
Hi-Index.....40.00

Lens Options — Co-Pay Amount

Executive Bifocal.....20.00

Tints & Coatings — Co-Pay Amount

Premium Scratch Coat.....00.00
Transitions.....00.00
Standard AR Coat.....40.00

Other Options — Co-Pay Amount

Rimless Groove.....7.50
Drill Mount.....15.00

Side Shields — Co-Pay Amount

Permanent 00.00
Detachable.....00.00

Dispensing — Co-Pay Amount

Dispensing Fee.....00.00
Eye Exam.....00.00

Co-Pay Total $_____

Supervisor Contact
Phone_____

Signature_____