TOTAL HEALTH CARE, INC.

Provider Name: _____ Fax #: _____

Member Name	DOB	ID Number	Date of Service	Eligible for Exam	Eligible for Glasses	Comment

To verify eligibility for vision services, complete the member demographics and date of service. Fax the form to **(313) 871-6406**. The Customer Service Department will complete the eligibility portion and return by fax within 1 business day. Thank you.