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 Fax: (714) 619-4662 ■ www.mesvision.com

Patient Name: _____
 Last 4 digits of SSN: _____
 OR Date of Birth: _____
 Provider Name: _____
 Date of Service: _____

Service Type (circle all that apply): Exam Lens Frame Contacts

Si usted prefiere este cuestionario en español, por favor llámenos o visite nuestro sitio web.

Medical Eye Services (**MESVision**) is the administrator for your company's vision plan. One of our corporate goals is to improve the delivery, claims processing, and servicing of your vision plan whenever possible. To this end, we would appreciate your cooperation in completing the following questionnaire. A pre-addressed envelope is enclosed for your convenience. Thank you.

Please rate the following:	EXCELLENT	GOOD	FAIR	POOR
1. Your experience with the examining provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Your experience with the eyewear provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Quality of examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Quality of eyewear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Provider staff's understanding of your vision plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you recently called MES Customer Service Department?			Yes <input type="checkbox"/>	No <input type="checkbox"/>
a) If yes, please rate the experience and explain below	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you recently accessed the MES website?			Yes <input type="checkbox"/>	No <input type="checkbox"/>
a) If yes, please rate your experience and explain below	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Please rate your overall experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Did you receive benefit material?			Yes <input type="checkbox"/>	No <input type="checkbox"/>
a) If yes, was the information in your benefit material helpful?			Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please provide suggested additions or changes to benefit material in space provided at the end of this survey.				
10. Did you find a participating provider in your area?			Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "No", please explain in the space provided at the end of this survey.				
11. When making your appointment, were you able to receive the appointment time within:				
<input type="checkbox"/> a) less than 1 week	<input type="checkbox"/> b) 1-2 weeks	<input type="checkbox"/> c) 3-4 weeks	<input type="checkbox"/> d) more than 4 weeks	
12. After your scheduled appointment, how long did you wait before vision care services began?				
<input type="checkbox"/> a) less than 10 minutes	<input type="checkbox"/> b) 10-20 minutes	<input type="checkbox"/> c) 21-30 minutes	<input type="checkbox"/> d) more than 30 minutes	
13. While at the provider's office:				
a) Were you interested in (and did you ask for) patient educational materials (vision care brochures, pamphlets, etc.)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If No, go to #14	
b) If interested, did you ask for and receive patient educational materials?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
c) If patient educational materials were not available, what vision care topics were you looking for?	_____			

14. Please specify your language preferences to help us improve our language assistance program.				
Preferred spoken language: _____				
Preferred written language: _____				
15. Were you able to easily communicate with the provider/provider staff during your office appointment, if your preferred spoken language is <i>not</i> English?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If No, please explain below.	

