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 Fax: (714) 619-4662 ■ [www.mesvision.com](http://www.mesvision.com)

**Patient Name:**  
**Provider Name:**  
**Date of Service:**  
**Service Type:**

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

Medical Eye Services (**MES Vision**) 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. We would greatly appreciate your feedback and have enclosed a pre-addressed envelope for your convenience. Thank you.

**Please rate the following:**

|  | EXCELLENT  | GOOD                                      | FAIR  | POOR   | N/A                             |
|--|--|---|---|--|---------------------------------|
| 1. Your experience with the examining provider   | <input type="checkbox"/>                         | <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"/>                         | <input type="checkbox"/>        |
| 3. Quality of examination  | <input type="checkbox"/>                         | <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"/>                         | <input type="checkbox"/>        |
| 5. Provider staff's understanding of your vision plan  | <input type="checkbox"/>                         | <input type="checkbox"/>                  | <input type="checkbox"/>                      | <input type="checkbox"/>                         | <input type="checkbox"/>        |
| 6. Did you feel the need to contact the MESVision Customer Service Department before or after using your vision benefits?  |  |   | Yes <input type="checkbox"/>                  | No <input type="checkbox"/>                      |                                 |
| a) If yes, please rate the experience and provide comments on the back.  | <input type="checkbox"/>                         | <input type="checkbox"/>                  | <input type="checkbox"/>                      | <input type="checkbox"/>                         | <input type="checkbox"/>        |
| 7. Did you feel the need to visit the MESVision website before or after using your vision benefits?  |  |   | Yes <input type="checkbox"/>                  | No <input type="checkbox"/>                      |                                 |
| a) If yes, please rate your experience and provide comments on the back.   | <input type="checkbox"/>                         | <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"/>                         | <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? Please provide suggested additions or changes to benefit material in space provided at the back of this page. |  |   | Yes <input type="checkbox"/>                  | No <input type="checkbox"/>                      |                                 |
| 10. Did you find a participating provider in your area? If "No", please complete and return the form enclosed.   |  |   | Yes <input type="checkbox"/>                  | No <input type="checkbox"/>                      |                                 |
| 11. When making your appointment, were you able to receive the appointment time within:  |  |   |   |  |                                 |
| <input type="checkbox"/> 1) less than 1 week   | <input type="checkbox"/> 2) 1-2 weeks            | <input type="checkbox"/> 3) 3-4 weeks     | <input type="checkbox"/> 4) more than 4 weeks | <input type="checkbox"/> 5) N/A                  |                                 |
| 12. a) After your scheduled appointment, how long did you wait before vision care services began?  | <input type="checkbox"/> 1) less than 10 minutes | <input type="checkbox"/> 2) 10-20 minutes | <input type="checkbox"/> 3) 21-30 minutes     | <input type="checkbox"/> 4) more than 30 minutes | <input type="checkbox"/> 5) N/A |
| b) If it was necessary, was your appointment re-scheduled timely?  | <input type="checkbox"/> 1) less than 1 week     | <input type="checkbox"/> 2) 1-2 weeks     | <input type="checkbox"/> 3) 3-4 weeks         | <input type="checkbox"/> 4) more than 4 weeks    | <input type="checkbox"/> 5) N/A |
| c) If you called your eye doctor after hours, did you get a message advising you how to obtain urgent or emergency care or to contact your medical provider/plan?              |  |   | Yes <input type="checkbox"/>                  | No <input type="checkbox"/>                      | N/A <input type="checkbox"/>    |
| 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. If your preferred spoken language is <i>not</i> English, were you able to easily communicate with the provider/provider staff during your office appointment?              | Yes <input type="checkbox"/>                     | No <input type="checkbox"/>               | If No, please explain on back of this page.   |  |                                 |
| 16. May MES share your survey responses/comments with your provider? This is used for quality improvement purposes.  | Yes <input type="checkbox"/>                     | No <input type="checkbox"/>               |   |  |                                 |