Mountain Health CO-OP
PO Box 45180
Salt Lake City, UT 84145
801.587.6480, Opt 2

It's important to stay healthy.
We're here to help you do just that.

At Mountain Health CO-OP, we see health insurance from a different perspective – providing care that meets you right where you are.

Our records show that you may be due for your diabetes eye exam.

Taking care of your eyes is very important. Diabetic retinopathy is the most common cause of new cases of blindness among adults aged 20-74 years. Eye problems like glaucoma and cataracts can take place earlier in people with diabetes. You can have the best vision if you get a dilated eye test once a year.

Things you should know about your eye benefits.

- Eye exam is covered for those with diabetes.
- This is a benefit even if you do not have a vision benefit.

How you can use this benefit.

- Tell your eye doctor that you have diabetes.
- Ask your eye doctor to tell your Primary Care Doctor the results of your test.

Call an eye doctor today and schedule an eye exam. If you need help finding a doctor, or scheduling a health screening, please call the Customer Service number on the back of your Member ID card, or visit www.mountainhealth.coop to find a provider in your area.

When you go to your eye doctor, bring this letter. Have your eye doctor send this letter back your primary care doctor.

Si necesita esta carta en Español, por favor llámenos al número de servicio al cliente ubicado detrás de su tarjeta de identificación de miembro.

Choose Healthy.
Choose Happy.
Choose You.

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Diabetes Eye Exam Communication Form

Patient Instructions

1. Schedule an eye exam with an Ophthalmologist (eye doctor).
2. Fill in Section 1 with your name, date of birth, and phone number and the name and contact information of your primary care doctor.
3. Take this form to an eye doctor and have them complete Section 2.
4. Bring this form back to your primary care doctor or ask the eye doctor to send/fax it to your primary care doctor.

Section 1 (to be completed by patient)

Member Name _____ **Member Date of Birth** ___ /___ / ___

Member Phone _____

Primary Care Doctor_____

Primary Care Doctor Address _____

Primary Care Doctor Phone _____**Primary Care Doctor Fax**_____

Section 2 (to be completed by Ophthalmologist/Eye Care Doctor)

Eye Exam Date ____ /____ / ____

Were eyes dilated for this exam? Yes ☐ No ☐

Exam Results:

____ No diabetic retinopathy
OD ☐ OS ☐

____ Non-proliferative Diabetic retinopathy
OD ☐ OS ☐

____ Proliferative Diabetic retinopathy
OD ☐ OS ☐

Follow-up Eye Exam recommendations:

____ 3 Months ____ 6 Months ____ 1 Year ____ Other

_____
Signature

Section 3 (Primary Care Doctor)

Please place this Diabetes Eye Exam Communication Form in the patient's medical record.