



State Employees' Health Insurance Plan

Diabetic Eye Examination Report

Patient Name: _____ DOB: ____/____/____

Insurance Contract Number: _____

Date of Diabetic Eye Exam: ____/____/____

Exam Findings:

____ Dilated Fundus Exam Performed

Diagnosis:

____ No Diabetic Retinopathy

____ Non-proliferative Diabetic Retinopathy

____ Mild

____ Moderate

____ Severe

____ Proliferative Diabetic Retinopathy

____ Diabetic Macular Edema

Eye Care Provider: _____

Eye Care Provider Signature: _____

Please return the completed form to:

Blue Cross Blue Shield of Alabama

Fax: 205.402.9411

OR

State Employees' Insurance Board Wellness Division

Email: wellness@alseib.org or Fax: 334.263.8631