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