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EYEGASSES PRIOR AUTHORIZATION REQUEST 2018

! Please begin using this form immediately and discard all previous versions.

For prior authorization submit via toll-free fax: 1 (800) 584-2329

REQUIRED INFORMATION

Patient Name _____	Provider Name _____
Patient DOB _____	Provider Panel # _____
Member Name _____	Provider Telephone # _____
Member ID # _____	Provider Fax # _____
	Date of Service _____

ADMINISTRATIVE BENEFIT REQUESTS

CIRCLE ALL THAT APPLY:

Exam _____	Eyeglasses _____	Lenses Only _____	Frame Only _____	2nd Pair in lieu of Bifocals _____
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REASON FOR REQUEST:

Prescription change _____	Lost _____	Broken _____	Other: _____
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EYEGASSES PRESCRIPTION

OLD PRESCRIPTION:

OD _____	SPHERE _____	CYLINDER _____	AXIS _____	ADD _____	PRISM _____
OS _____	SPHERE _____	CYLINDER _____	AXIS _____	ADD _____	PRISM _____

NEW PRESCRIPTION:

OD _____	SPHERE _____	CYLINDER _____	AXIS _____	ADD _____	PRISM _____
OS _____	SPHERE _____	CYLINDER _____	AXIS _____	ADD _____	PRISM _____

MEDICAL CONDITIONS

Is patient Diabetic?
YES / NO _____

Is patient Insulin Dependent?
YES / NO _____

Does patient have cataracts?
YES / NO _____

Has patient had cataract surgery?
YES / NO _____

Which eye?
OD / OS _____

Other medical condition:

PROVIDER COMMENTS

FOR DAVIS VISION USE ONLY - PLEASE DO NOT WRITE IN THE FIELDS BELOW

Determination Date: _____ AUTH #: _____ Authorized: YES/NO _____ Reviewed by: _____

COMMENTS:

THIS REQUEST IS BEING REJECTED FOR THE REASON LISTED BELOW. THIS IS NOT A DENIAL.

- ___ **Missing/Invalid Information:** Patient Name Patient ID Provider Number Services Requested Old/New RX Other: _____
- ___ **Eyeglasses are covered under warranty. Contact Order Entry at 1 (800) 933-9375. Refer to AUTH #** _____
- ___ **A denial determination has already been made on the requested services. Please follow appeal instructions as listed on the notification.**
- ___ **Member is termed** ___ **Illegible** ___ **Other** _____

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