DavisVision™

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EYEGLASSES 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 _____

Patient DOB _____

Member Name _____

Member ID # _____

Provider Name _____

Provider Panel # _____

Provider Telephone # _____

Provider Fax # _____

Date of Service _____

ADMINISTRATIVE BENEFIT REQUESTS

CIRCLE ALL THAT APPLY:

Exam | Eyeglasses | Lenses Only | Frame Only | 2nd Pair in lieu of Bifocals

REASON FOR REQUEST:

Prescription change | Lost | Broken | Other: _____

EYEGLASSES PRESCRIPTION

OLD PRESCRIPTION:

	SPHERE	CYLINDER	AXIS	ADD	PRISM
OD					
OS					

NEW PRESCRIPTION:

	SPHERE	CYLINDER	AXIS	ADD	PRISM
OD					
OS					

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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