

**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 NPI _____
Member ID # _____	Provider Telephone # _____
Date of Service _____	Provider Fax # _____

**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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