

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

Form with fields for Patient Name, Patient DOB, Member Name, Member ID #, Provider Name, Provider Panel #, Provider Telephone #, Provider Fax #, and Date of Service.

ADMINISTRATIVE BENEFIT REQUESTS

Form with sections for 'CIRCLE ALL THAT APPLY:' (Exam, Eyeglasses, Lenses Only, Frame Only, 2nd Pair in lieu of Bifocals) and 'REASON FOR REQUEST:' (Prescription change, Lost, Broken, Other).

EYEGASSES PRESCRIPTION

Form with sections for 'OLD PRESCRIPTION:' and 'NEW PRESCRIPTION:', each with fields for OD and OS, SPHERE, CYLINDER, AXIS, ADD, and PRISM.

MEDICAL CONDITIONS

Form with questions: 'Is patient Diabetic?', 'Is patient Insulin Dependent?', 'Does patient have cataracts?', 'Has patient had cataract surgery?', 'Which eye?', and 'Other medical condition:'.

PROVIDER COMMENTS

Large empty box for PROVIDER COMMENTS.

FOR FEP BLUEVISION USE ONLY - PLEASE DO NOT WRITE IN THE FIELDS BELOW

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

Form with 'COMMENTS:' label and a large empty box for text.

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

Form with rejection reasons: 'Missing/Invalid Information', 'Eyeglasses are covered under warranty', 'A denial determination has already been made', and 'Member is termed Illegible'.

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