DAVIS VISION
EYECARE REFRAMED℠
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MEDICALLY NECESSARY 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 # _____

SERVICE (CIRCLE ALL APPLICABLE)

Medically Necessary Contact Lens Evaluation | Medically Necessary Contact Lenses | Low Vision Exam | Low Vision Aids

EYEGLASSES PRESCRIPTION

	SPHERE	CYLINDER	AXIS	ADD	PRISM	20/ VISUAL ACUITIES
OD						
OS						

CONTACT LENS PRESCRIPTION (IF AVAILABLE)

	SPHERE	CYLINDER	AXIS	20/ VISUAL ACUITIES
OD				
OS				

KERATOMETRY READINGS

OD _____

OS _____

MEDICALLY NECESSARY CONTACT LENS REQUIREMENTS (ICD 10 DX Codes Required)

Medically Necessary / Visually Required Contact Lenses are only available for the diagnoses listed below - CIRCLE ALL APPLICABLE:

Keratoconus (K Readings and/or topography) | Aphakia | Aniridia | Anisometropia (Eyeglasses - Rx differ more than 3dp) | Irregular Astigmatism

High Ametropia
1. Eyeglass prescription is ≥-8.00 or≥ +8.00 diopters in any meridian of one or both eyes
2. AND, eyeglass best corrected visual acuity of 20/40 or worse in either eye
3. AND, visual acuity improvement of 2 lines or more with contact lenses

Professional Fee $ _____

Material Fee $ _____

☐ Contact Lenses ☐ Low Vision Aids

PROVIDER COMMENTS (For clinical extenuating circumstances, please attach the medical record or relevant clinical information, patient history, previous ineffective treatment, or occupational considerations)**:**

_____

X _____

I attest the information provided is true and accurate.

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

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

COMMENTS:

A claim must be submitted for all medically necessary contact lens requests to include a copy of the prior authorization form. Authorizations for medically necessary contact lenses are not a guarantee of payment. Final eligibility will be determined when the claim is processed. All claims are subject to a maximum allowable fee.

For reimbursement purposes, please ensure that the appropriate contact lens fitting code is submitted as per the current American Medical Association CPT definition. All materials prescribed should be described by the appropriate HCPCS Level II code as per the current American Medical Association Healthcare Procedural Coding System definition. All reimbursement rates are for combined professional services and/or materials.

To submit claims via mail or fax: Vision Care Processing; Unit P.O. Box 1525; Latham, New York 12110; 1 (888) 328-4761