DAVIS VISION
EYECARE REFRAMED℠

# ADDITIONAL INFORMATION FORM

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

## REQUIRED INFORMATION

Patient Name _____

Patient DOB _____

Member Name _____

Member ID # _____

Date of Service _____

Provider Name _____

Provider Panel # _____

Provider NPI _____

Provider Telephone # _____

Provider Fax # _____

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

Determination Date: _____ Reviewed by: _____ Authorized: **YES / NO**

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.

CONFIDENTIALITY NOTE: The information contained in the facsimile is confidential and intended for the use of the addressee shown above. if you are neither the intended recipient nor the employer agent responsible for delivering this message, you are hereby notifiied that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopy information is strictly prohibited. If you have received this telecopy in error, please notify us by telephone to arrange for its return.

Davis Vision only provides routine vision care, therefore urgent or emergency reviews are are not applicable.

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