

# DAVIS VISION

EYECARE REFRAMED<sup>SM</sup>

## LABORATORY ORDER FORM

PANEL #: \_\_\_\_\_ PRACTITIONER IDENTIFIER: \_\_\_\_\_

SERVICING PRACTITIONER NAME: \_\_\_\_\_

AUTHORIZATION #: \_\_\_\_\_ MEMBER ID#: \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ PANEL FAX # \_\_\_\_\_

Pair # (1= 1st pair, etc.): \_\_\_\_\_ **TYPE:** Dress  VDT  Safety  Occupational  Date of Service \_\_\_\_\_

**TYPE:** REDO  Redo Reason: \_\_\_\_\_

**SERVICES:**

Examination: Yes  No

Contact lens evaluation and fitting: Yes  No

If yes: Daily Wear  or Extended Wear

Contact lens evaluation and fitting cost\* \$ \_\_\_\_\_

Is this an occupational/VDT exam\*: Yes  No

\*Only applicable for specific groups; please refer to group specific plan outline.

**The information below is required to process an exam order.**

Is this a new patient? Yes  No

Did you provide a comprehensive exam? Yes  No

Dilation: Yes  No

Primary Diagnosis (ICD-10) Code (**required**): \_\_\_\_\_

Additional Diagnosis Code(s) (if any): \_\_\_\_\_

**LENS MATERIALS:**

Plastic  High Index  (Specify Index: \_\_\_\_\_)

Plastic Photosensitive  GRY \_\_\_\_\_ BRN \_\_\_\_\_ TYPE \_\_\_\_\_

Polycarbonate  (No charge for dependent children, monocular patients and/or prescriptions +/- 6 diopters or greater.)

Glass  PGX \_\_\_\_\_ PBX \_\_\_\_\_ CLR \_\_\_\_\_

Other  (Specify Other: \_\_\_\_\_)

**LENS COATINGS:**

UV  ARC  TYPE \_\_\_\_\_

SCRATCH-RESISTANT COATING

COLOR OF TINT	PERCENTAGE	SOLID <input type="checkbox"/>
		GRADIENT <input type="checkbox"/>

SPECIAL INSTRUCTIONS: \_\_\_\_\_

**PRESCRIPTION INFORMATION:**

SPHERE	CYLINDER	AXIS	PD/DIST	PD/NEAR	PRISM	BASE	PD:
R:							BINOCULAR <input type="checkbox"/> MONOCULAR <input type="checkbox"/>
L:							

**MULTIFOCAL SPECIFICATIONS:** (NOTE: PLEASE ALWAYS SPECIFY LENS TYPE, I.E., STRAIGHT TOP 35, VARLUX COMFORT.)

TYPE	ADD	SEG HEIGHT	BASE CURVE	OC HEIGHT
R:				
L:				

**FRAME:**

MFG	FRAME NAME	EYE	BRIDGE	TEMPLE	COLOR	FRAME TYPE
						Plan <input type="checkbox"/> Non-Plan <input type="checkbox"/> (complete Non-Plan frame info below)

↔ **Non-Plan Frames** ↔

*All orders requiring a patient's frame or a frame from your office be sent to one of our Davis Vision Laboratories should be shipped with the provided packing slip the same day the packing slip is received.*

**NON-PLAN FRAMES:**

Patient's Own  Provider Supplied  Frame Cost \$ \_\_\_\_\_ (Retail Cost   
 (Wholesale Cost )

Grooved

Frame to follow YES  NO  Rimless  Full  Drilled: 2 Hole  4 Hole

IF NO: A \_\_\_\_\_ B \_\_\_\_\_ ED \_\_\_\_\_ CIRC \_\_\_\_\_

**NON-PLAN LENSES / CONTACT LENSES:**

Patient's Own  Provider Supplied  Disposable

Type: SV  BI  TRI  Contacts  Non-Disposable

Lens Cost \$ \_\_\_\_\_ (Retail Cost)

**CONTACT LENSES:** NEW WEARER  EXISTING WEARER  (Plan Supplied)

Manufacturer: \_\_\_\_\_ Series: \_\_\_\_\_

Number of boxes per eye: \_\_\_\_\_ (if applicable, see provider outline)

SPHERE	CYLINDER	BASE	DIAMETER
R:			
L:			

**If you have any questions or do not receive a fax confirmation within 24 hours, please contact:**  
**Phone: 1-800-933-9375 or E-mail Address: [Orders@davisvision.com](mailto:Orders@davisvision.com)**  
**You can place orders online at [www.davisvision.com](http://www.davisvision.com)**