

DAVIS VISION

EYECARE REFRAMEDSM

PRIOR APPROVAL REQUEST FORM

Submit To: Toll Free Fax 1-800-584-2329

Received by Davis Vision

Important: PLEASE VERIFY MEMBER BENEFIT PRIOR TO SUBMITTING REQUEST.

Patient Information

Patient Name		Member ID Number	Member Name
Patient DOB	New Patient Yes <input type="checkbox"/> No <input type="checkbox"/>	Group Employer Name	Date of Service

Provider Information

Provider Name (Please Print)	Provider Panel Number (Required)	Date of Request
Provider Email Address	Provider Telephone Number	Provider Fax Number

Please Mark Services Requested

Exam Only <input type="checkbox"/>	Eyeglasses only <input type="checkbox"/>	Low Vision Evaluation <input type="checkbox"/>	Additional Exam <input type="checkbox"/>
Exam & Eyeglasses <input type="checkbox"/>	Repair/Replace Reason: _____ <input type="checkbox"/>	Contact Lens Evaluation <input type="checkbox"/>	

Is there a medical condition related to this request? No Yes

Keratoconus <input type="checkbox"/>	Progressive Myopia <input type="checkbox"/>	Anisometropia <input type="checkbox"/>	Post Cataract Date Last Surgery: <input type="checkbox"/>
Aphakia <input type="checkbox"/>	Pathological Myopia <input type="checkbox"/>	Diabetes <input type="checkbox"/>	_____
			Other: _____ <input type="checkbox"/>

Provider Comments:	Supporting Documents Attached <input type="checkbox"/>
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Prescription Information Required

Rx Glasses	OD	VA OD /	Professional Fee \$	Material Fee \$
	OS	VA OS /		
Contact Lenses <input type="checkbox"/> Low Vision Aids <input type="checkbox"/> Eyeglasses <input type="checkbox"/>				
Contact Lenses	OD	VA OD /	Material U & C Fee:	
	OS	VA OS /		

Both Old and New Prescription Must Be Completed Below for Requests Related to Changes in Rx

Old Rx:	OD	New Rx:	OD
	OS		OS

FOR DAVIS VISION USE ONLY – PLEASE DO NOT WRITE BELOW THIS AREA

Approved Date	Authorization Number/Benefit	Denied Date	Reviewed By: Signature:
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Comments:		
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Additional Information Required	Date Requested	Date Received
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