DAVIS VISION
EYECARE REFRAMED℠

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** ☐ **No** ☐	**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	☐	Eyeglasses only	☐	Low Vision Evaluation	☐	Additional Exam	☐
Exam & Eyeglasses	☐	Repair/Replace Reason: _____	☐	Contact Lens Evaluation	☐		

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

Keratoconus	☐	Progressive Myopia	☐	Anisometropia	☐	Post Cataract *Date Last Surgery:* _____	☐
Aphakia	☐	Pathological Myopia	☐	Diabetes	☐		
						Other: _____	☐

Provider Comments:	**Supporting Documents Attached** ☐

Prescription Information Required

Rx Glasses	OD OS	VA OD / VA OS /	**Professional Fee $**	**Material Fee $** Contact Lenses ☐ Low Vision Aids ☐ Eyeglasses ☐
Contact Lenses	OD OS	VA OD / VA OS /	**Material U & C Fee:**	

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

Old Rx:	OD OS	**New Rx:**	OD OS

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

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