DAVIS VISION
EYECARE REFRAMED℠

PRIOR AUTHORIZATION REQUEST 2017

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 _____

Patient DOB _____

Member Name _____

Member ID # _____

Provider Name _____

Provider Panel # _____

Provider Telephone # _____

Provider Fax # _____

Date of Service _____

ADMINISTRATIVE BENEFIT REQUESTS

CIRCLE ONE:

Exam Only	Eyeglasses Only	Low Vision Evaluation	Repair / Broken	Diabetic Member Is member insulin dependent? YES NO
Exam & Eyeglasses	Polycarbonate Lenses	Low Vision Aids	Replace / Lost	Post Cataract Surgery OD OS Date: _____

EYEGLASSES PRESCRIPTION

		SPHERE	CYLINDER	AXIS	ADD	PRISM	VISUAL ACUITIES
PREVIOUS RX	OD						20/
	OS						20/
NEW RX	OD						20/
	OS						20/

CONTACT LENS PRESCRIPTION

	SPHERE	CYLINDER	AXIS	VISUAL ACUITIES
OD				20/
OS				20/

KERATOMETRY READINGS

OD _____

OS _____

MEDICALLY NECESSARY CONTACT LENS REQUIREMENTS

VA's required for all medically necessary contact lens requests. When submitting the claim form, please include a copy of the prior authorization form.

Professional Fee $ _____

Material Fee $ _____

☐ Contact Lenses ☐ Low Vision Aids ☐ Eyeglasses

CIRCLE ALL APPLICABLE:
PLEASE PROVIDE ALL DOCUMENTATION TO SUPPORT DIAGNOSES.

Medically Necessary Contact Lens Evaluation

Medically Necessary Contact Lenses

Keratoconus
(Eyeglasses / Contacts Lens Rx- VA's, K's or Topography and clinical notes)

Anisometropia
(Eyeglasses - Rx differ more than 3dp)

High Ametropia
(Eyeglasses - Rx exceeds +/-7dp in any meridian)

Aphakia
(Clinical Documentation)

Aniridia
(Clinical Documentation)

PROVIDER COMMENTS:

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

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

Comments: _____

AUTH #:
(if applicable)

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.

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