

**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 _____	Provider Name _____
Patient DOB _____	Provider Panel # _____
Member Name _____	Provider Telephone # _____
Member ID # _____	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: _____

**EYEGASSES PRESCRIPTION**

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

**CONTACT LENS PRESCRIPTION**

OD _____	SPHERE	CYLINDER	AXIS	20/ VISUAL ACUITIES
OS _____	SPHERE	CYLINDER	AXIS	20/ VISUAL ACUITIES

**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.

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

Medically Necessary Contact Lens Evaluation	Keratoconus (Eyeglasses / Contacts Lens Rx- VA's, K's or Topography and clinical notes)	High Ametropia (Eyeglasses - Rx exceeds +/-7dp in any meridian)
Medically Necessary Contact Lenses	Anisometropia (Eyeglasses - Rx differ more than 3dp)	Aphakia (Clinical Documentation)      Aniridia (Clinical Documentation)

Professional Fee \$ \_\_\_\_\_

Material Fee \$ \_\_\_\_\_

Contact Lenses       Low Vision Aids       Eyeglasses

**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.

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