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EYEGLASSES PRIOR AUTHORIZATION REQUEST

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 ALL THAT APPLY:

Exam   Eyeglasses   Lenses Only   Frame Only   2nd Pair in lieu of Bifocals

REASON FOR REQUEST:

Prescription change   Lost   Broken   Other: ______________

EYEGLASSES PRESCRIPTION

OLD PRESCRIPTION:

	SPHERE	CYLINDER	AXIS	ADD	PRISM
OD					
OS					

NEW PRESCRIPTION:

	SPHERE	CYLINDER	AXIS	ADD	PRISM
OD					
OS					

MEDICAL CONDITIONS

Is patient Diabetic?
YES / NO

Is patient Insulin Dependent?
YES / NO

Does patient have cataracts?
YES / NO

Has patient had cataract surgery?
YES / NO

Which eye?
OD / OS

Other medical condition:
____

PROVIDER COMMENTS

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

Determination Date: __________ AUTH #: ______________________ Authorized: YES/NO Reviewed by: ______________

COMMENTS:

THIS REQUEST IS BEING REJECTED FOR THE REASON LISTED BELOW. THIS IS NOT A DENIAL.

___**Missing/Invalid Information:** Patient Name   Patient ID   Provider Number   Services Requested   Old/New RX   Other: ______________

___**Eyeglasses are covered under warranty. Contact Order Entry at 1 (800) 933-9375. Refer to AUTH #** ______________________

___**A denial determination has already been made on the requested services. Please follow appeal instructions as listed on the notification.**

_______**Member is termed**   _______**Illegible**   _______**Other** ______________________

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