DavisVision™
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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 # _____

Date of Service _____

Provider Name _____

Provider Panel # _____

Provider NPI _____

Provider Telephone # _____

Provider Fax # _____

## 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:**

OD _____ SPHERE | CYLINDER | AXIS | ADD | PRISM

OS _____ SPHERE | CYLINDER | AXIS | ADD | PRISM

**NEW PRESCRIPTION:**

OD _____ SPHERE | CYLINDER | AXIS | ADD | PRISM

OS _____ SPHERE | CYLINDER | AXIS | ADD | PRISM

## 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** _____



Davis Vision only provides routine vision care, therefore urgent or emergency reviews are are not applicable.

DV-PRO18-0328v1 PDF 8/2018