DavisVision™

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# MEDICALLY NECESSARY 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 | _____ | Provider Name | _____ |
| Patient DOB | _____ | Provider Panel # | _____ |
| Member Name | _____ | Provider NPI | _____ |
| Member ID # | _____ | Provider Telephone # | _____ |
| Date of Service | _____ | Provider Fax # | _____ |

## SERVICE (CIRCLE ALL APPLICABLE)

Medically Necessary Contact Lens Evaluation | Medically Necessary Contact Lenses | Low Vision Exam | Low Vision Aids

## EYEGLASSES PRESCRIPTION

| | SPHERE | CYLINDER | AXIS | ADD | PRISM | VISUAL ACUITIES |
|---|---|---|---|---|---|---|
| OD | | | | | | 20 / |
| OS | | | | | | 20 / |

## CONTACT LENS PRESCRIPTION (IF AVAILABLE)

| | SPHERE | CYLINDER | AXIS | VISUAL ACUITIES |
|---|---|---|---|---|
| OD | | | | 20 / |
| OS | | | | 20 / |

## KERATOMETRY READINGS

OD _____

OS _____

## MEDICALLY NECESSARY CONTACT LENS REQUIREMENTS (ICD 10 DX Codes Required)

**Medically Necessary / Visually Required Contact Lenses are only available for the diagnoses listed below - CIRCLE ALL APPLICABLE:**

Aphakia | Aniridia | Anisometropia (Eyeglasses - Rx differ more than 3dp) | Stable Keratoconus (K Readings and/or topography/clinical notes) | Irregular Astigmatism

High Ametropia
1. Eyeglass prescription is ≥ -8.00 or ≥+8.00 diopters in any meridian of one or both eyes
2. AND, eyeglass best corrected visual acuity of 20/40 or worse in either eye
3. AND, visual acuity improvement of 2 lines or more with contact lenses

Unstable Keratoconus (K Readings and/or topography/clinical notes)

**Professional Fee $** _____

**Material Fee $** _____

☐ Contact Lenses ☐ Low Vision Aids

**PROVIDER COMMENTS** (For clinical extenuating circumstances, please attach the medical record or relevant clinical information, patient history, previous ineffective treatment, or occupational considerations):

_____

X _____

**I attest the information provided is true and accurate.**

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

Determination Date: _____ AUTH #: _____ Authorized: YES/NO Reviewed by: _____

**COMMENTS:**



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.

For reimbursement purposes, please ensure that the appropriate contact lens fitting code is submitted as per the current American Medical Association CPT definition. All materials prescribed should be described by the appropriate HCPCS Level II code as per the current American Medical Association Healthcare Procedural Coding System definition. All reimbursement rates are for combined professional services and/or materials.

**Once you have received prior authorization, attach this form to the HCFA 1500 and submit to: Vision Care Processing; Unit P.O. Box 1525; Latham, New York 12110; or fax 1 (888) 328-4761**

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