DAVIS VISION
EYECARE REFRAMED℠

VERIZON (FORMERLY BELL ATLANTIC SOUTH) FAX LABORATORY ORDER FORM

PANEL #: _____ PRACTITIONER IDENTIFIER: _____

PANEL FAX #: _____ MEMBER ID#: _____

PATIENT NAME: _____ AUTHORIZATION # _____

Pair # (1= 1st pair, etc.): _____ **TYPE:** Dress ☐ VDT ☐ Safety ☐ Date of Service _____

SERVICES:

Examination: Yes ☐ No ☐

The information below is required to process an exam order.

Is this a new patient? Yes ☐ No ☐
Did you provide a comprehensive exam? Yes ☐ No ☐
Dilation: Yes ☐ No ☐
Primary Diagnosis (ICD-10) Code: _____
Additional Diagnosis ICD-10 Code (if applicable): _____

Please send your completed order form by email to orders@davisvision.com.
If there are any questions, please contact our Order Entry team by phone at 1-800-888-4321.
For doctor supplied contact lenses, please fax your completed form to 1-888-328-4761.

***** PLEASE NOTE: All necessary information must be completed prior to faxing this form.**

LENS MATERIALS:

Plastic ☐ Photosensitive ☐ High Index ☐ (Specify Index: _____)
Polycarbonate ☐ (No fee for dep. child / monocular and +/- 6.00 diopter patients)
Glass ☐ PGX ___ PBX ___ CLR ___
Other ☐ (Specify Other: _____)

LENS COATINGS:

UV ☐ AR ☐ HARDCOAT ☐

COLOR OF TINT	PERCENTAGE

SPECIAL INSTRUCTIONS:

	SPHERE	CYLINDER	AXIS	PD/DIST	PD/NEAR	PRISM	BASE
R:							
L:							

BINOCULAR PD ☐
MONOCULAR PD ☐
HORIZONTAL PD ☐

	TYPE	ADD	SEG HEIGHT	BASE CURVE	OC HEIGHT
R:					
L:					

MFG	FRAME NAME	EYE	BRIDGE	TEMPLE	COLOR	FRAME TYPE
						Plan ☐ Non-Plan ☐ (complete Non-Plan frame info below)

MULTIFOCAL SPECIFICATIONS: (NOTE: IF PROGRESSIVE LENSES, PLEASE SPECIFY LENS TYPE)

NON-PLAN FRAMES: Frame to follow YES ☐ NO ☐ Rimless ☐ Full ☐

Patient's Own ☐ Provider Supplied ☐ Frame Cost $_____ Retail Cost $_____ IF NO, A _____ B _____ ED _____

DAVIS VISION SUPPLIED CONTACT LENSES

DAVIS VISION WILL SUPPLY THE FOLLOWING LENS TYPES
(MUST PLACE ORDER WITH DV LABORATORY):
SPHERICAL CONVENTIONAL SOFT
SPHERICAL DISPOSABLE/PLANNED REPLACEMENT

LENS TYPE: _____

MANUFACTURER (BRAND): _____

	POWER	BASE	DIAMETER
R:			
L:			

☐ New Fit ☐ Refit Total # of Boxes _____

DOCTOR SUPPLIED CONTACT LENSES

PLEASE FOLLOW THE FORMULA BELOW FOR ALL DOCTOR SUPPLIED CONTACT LENSES:
(Toric, Spherical Gas Permeable, PMMA, Bifocal, and all other types)
(WHOLESALE ACQUISITION COST + FITTING FEES) – ($25.00 MEMBER COPAYMENT)

☐ $85.00 FITTING FEE FOR SPHERICAL SOFT LENSES
☐ $110.00 FITTING FEE FOR ALL OTHER SPECIALTY LENSES

LENS TYPE: _____
MANUFACTURER (BRAND): _____
NUMBER OF VIALS / BOXES (1YR SUPPLY): _____
WHOLESALE ACQUISITION COST: _____

* Reported wholesale acquisition costs are subject to audit and verification. Please be able to provide an invoice including discounts received. Manufacturers' list prices are verified.

	POWER	BASE	DIAMETER
R:			
L:			

Colored Contact Lenses are not covered

Signature of Staff Member _____