

## PRIOR APPROVAL / MEDICALLY NECESSARY SERVICES REQUEST FORM

**Submit To: Toll Free Fax 1-800-584-2329**

**Questions? Call: 1-800-328-4728 x6811**

**IMPORTANT: PLEASE VERIFY MEMBER BENEFIT PRIOR TO SUBMITTING REQUEST.**

**Patient Information**

Patient Name (Please Print)			Member/Patient ID Number		
Patient Date of Birth	New Patient	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Group/Employer Name	

**Provider Information**

Provider Name (Please Print)		Provider Panel Number	Today's Date
Provider Telephone Number		Provider Fax Number	

**Services Requested**

**Diagnosis/Reason for Services**

Exam Only <input type="checkbox"/>	Contact Lens Evaluation <input type="checkbox"/>	Keratoconus <input type="checkbox"/>	Progressive Myopia <input type="checkbox"/>
Exam & Eyeglasses <input type="checkbox"/>	Contact Lenses <input type="checkbox"/>	Aphakia/Post Cataract <input type="checkbox"/>	Pathological Myopia <input type="checkbox"/>
Eyeglasses Only <input type="checkbox"/>	Low Vision Evaluation <input type="checkbox"/>	Anisometropia <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Repair/Replace <input type="checkbox"/>	Low Vision Aids <input type="checkbox"/>		Other _____
	Additional Exam <input type="checkbox"/>		

**Provider Comments**

**Supporting Documents Attached**

**Prescription Information**

**Fees (Information Required)**

<b>Rx Eyeglasses</b>	OD	VA OD	Professional Fee \$ _____
	OS	VA OS	
<b>Contact Lenses</b>	OD	VA OD	Material Fee \$ _____ Contact Lenses <input type="checkbox"/> Low Vision Aids <input type="checkbox"/> Eyeglasses <input type="checkbox"/>
	OS	VA OS	

**BOTH OLD AND NEW PRESCRIPTION MUST BE COMPLETED BELOW FOR REQUESTS RELATED TO SIGNIFICANT CHANGES IN RX.**

<b>Old Rx</b>	OD	<b>New Rx</b>	OD
	OS		OS

**FOR DAVIS VISION USE ONLY – DO NOT WRITE BELOW THIS AREA**

Approved Date	Auth No./Benefit	Denied Date	Reviewed By:  Signature
Comments:			
Additional Information Required			Date Requested
			Date Received

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