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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 ☐ No ☐	Group/Employer Name

Provider Information

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

Services Requested

Exam Only ☐	Contact Lens Evaluation ☐	Keratoconus ☐	Progressive Myopia ☐
Exam & Eyeglasses ☐	Contact Lenses ☐	Aphakia/Post Cataract ☐	Pathological Myopia ☐
Eyeglasses Only ☐	Low Vision Evaluation ☐	Anisometropia ☐	Diabetes ☐
Repair/Replace ☐	Low Vision Aids ☐		Other _____
	Additional Exam ☐		

Diagnosis/Reason for Services

Provider Comments **Supporting Documents Attached** ☐

Prescription Information

Rx Eyeglasses	OD OS	VA OD VA OS
Contact Lenses	OD OS	VA OD VA OS

Fees (Information Required)

Professional Fee $_____

Material Fee $_____

Contact Lenses ☐ Low Vision Aids ☐ Eyeglasses ☐

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

Old Rx	OD OS	**New Rx**	OD 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