DAVISVISION®

SEE LIFE

LABORATORY ORDER FORM

PANEL #: _____ PRACTITIONER IDENTIFIER: _____

SERVICING PRACTITIONER NAME: _____

AUTHORIZATION #: _____ MEMBER ID#: _____

PATIENT NAME _____ PANEL FAX # _____

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

TYPE: REDO ☐ Redo Reason: _____ EXCEL ADVANTAGE ☐

SERVICES:

Examination: Yes ☐ No ☐

Contact lens evaluation and fitting: Yes ☐ No ☐

If yes: Daily Wear ☐ or Extended Wear ☐

Contact lens evaluation and fitting cost* $ _____

Is this an occupational/VDT exam*: Yes ☐ No ☐

*Only applicable for specific groups; please refer to group specific plan outline.

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-9) Code (**required**): _____

Secondary Diagnosis Code (if any): _____

LENS MATERIALS:

Plastic ☐ High Index ☐ (Specify Index: _____)

Plastic Photosensitive ☐ GRY ___ BRN ___ TYPE _____

Polycarbonate ☐ (No charge for dependent children, monocular patients and/or prescriptions +/- 6 diopters or greater.)

Glass ☐ PGX ___ PBX ___ CLR ___

Other ☐ (Specify Other: _____)

LENS COATINGS:

UV ☐ ARC ☐ TYPE _____

SCRATCH-RESISTANT COATING ☐

COLOR OF TINT	PERCENTAGE	SOLID ☐
		GRADIENT ☐

SPECIAL INSTRUCTIONS:

PRESCRIPTION INFORMATION:

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

PD:

BINOCULAR ☐

MONOCULAR ☐

MULTIFOCAL SPECIFICATIONS: (NOTE: PLEASE ALWAYS SPECIFY LENS TYPE, I.E., STRAIGHT TOP 35, VARLUX COMFORT.)

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

FRAME:

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

NON-PLAN FRAMES:

Patient's Own ☐ Provider Supplied ☐ Frame Cost $ _____ (Retail Cost ☐)
(Wholesale Cost ☐)

Frame to follow YES ☐ NO ☐ Grooved Rimless ☐ Full ☐ Drilled: 2 Hole ☐ 4 Hole ☐

IF NO: A _____ B _____ ED _____ CIRC _____

NON-PLAN LENSES / CONTACT LENSES:

Patient's Own ☐ Provider Supplied ☐ Disposable ☐

Type: SV ☐ BI ☐ TRI ☐ Contacts ☐ Non-Disposable ☐

Lens Cost $_____(Retail Cost)

CONTACT LENSES: NEW WEARER ☐ EXISTING WEARER ☐ (Plan Supplied)

Manufacturer: _____ Series: _____

Number of boxes per eye:_____ (if applicable, see provider outline)

	SPHERE	CYLINDER	BASE	DIAMETER
R:				
L:				

If you have any questions or do not receive a fax confirmation within 24 hours, please contact:

Phone: 1-800-888-4321

You can place orders online at www.davisvision.com