

DAVIS VISION

EYECARE REFRAMEDSM

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 <input type="checkbox"/>
		GRADIENT <input type="checkbox"/>

SPECIAL INSTRUCTIONS:

PRESCRIPTION INFORMATION:

SPHERE	CYLINDER	AXIS	PD/DIST	PD/NEAR	PRISM	BASE	PD:
R:							BINOCULAR <input type="checkbox"/> MONOCULAR <input type="checkbox"/>
L:							

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 <input type="checkbox"/> Non-Plan <input type="checkbox"/> (complete Non-Plan frame info below)

↔ **Non-Plan Frames** ↔

All orders requiring a patient's frame or a frame from your office be sent to one of our Davis Vision Laboratories should be shipped with the provided packing slip the same day the packing slip is received.

NON-PLAN FRAMES:

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

Grooved

Frame to follow YES NO 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