DavisVision

Date of Request:

Routine Vision Services Authorization Request Form

Use This Form For: Authorization Requests for Routine Vision Services. *Please check the specific health plan requirements for services that need a prior authorization. Not all services are covered by all Plans.*

Return fax to: (800) 584-2329

Please include medical records with all requests. Failure to submit the required documentation may result in a denial.

MEMBER INFORMATION:

Member Name: _____ Date of Birth: _____

Member ID: _____ Member's Health Plan: _____

Member Address: _____

RENDERING PROVIDER INFORMATION:

Rendering Provider Name: _____ Rendering Provider Contact Name: _____

Rendering Provider NPI: _____ Rendering Provider Contact Phone: _____

Rendering Provider Panel #: _____ Rendering Provider Contact Fax: _____

Rendering Provider Correspondence Address: _____

SERVICES BEING REQUESTED: Based on plan coverage, services requested may include: specialty lenses, contact lenses, replacement glasses, low vision aids, additional eye exams and vision therapy. Please print clearly to avoid delays in processing. For extenuating circumstances, please attach the medical record or relevant clinical information, patient history, previous ineffective treatment or occupational considerations.

Please provide a description and **CPT code** for the services being requested: _____

Please provide all applicable diagnosis codes: _____ Date of Service: _____

Please provide any additional relevant information: _____

EYEGLASS PRESCRIPTION INFORMATION: **Dispensing Date**

Previous Prescription:

O D : _____ 2 0 /
SPHERE CYLINDER AXIS ADD PRISM VISUAL ACUITIES

O S : _____ 2 0 /
SPHERE CYLINDER AXIS ADD PRISM VISUAL ACUITIES

New Prescription:

O D : _____ 2 0 /
SPHERE CYLINDER AXIS ADD PRISM VISUAL ACUITIES

O S : _____ 2 0 /
SPHERE CYLINDER AXIS ADD PRISM VISUAL ACUITIES

MEDICALLY NECESSARY CONTACT LENSES PRESCRIPTION INFORMATION: **Dispensing Date**

KERATOMETRY READINGS

OD: _____ 20/ OD _____
SPHERE CYLINDER AXIS VISUAL ACUITIES

OS: _____ 20/ OS _____
SPHERE CYLINDER AXIS VISUAL ACUITIES

Medically Necessary Contact Lenses requests must include: Clinical Notes with Exam findings, Topography, Keratometric readings, Manifest Refraction and BCVA.

PROVIDER'S SIGNATURE:

_____ **DATE:** _____

I attest that the requested material or service is medically necessary (unsigned forms will not be considered for coverage under medical necessity

REQUESTED TIMING FOR AUTHORIZATION REVIEW:

☐ **Non-Urgent**: Patient's life, health (vision) or ability to regain box, maximum function is not at risk if a decision is rendered under the standard timeframe or if procedure has already been performed. Non-Urgent is assumed if neither box is checked.

☐ **Urgent:** This reason should not apply to routine services. By checking this you are certifying the physician has ordered that the request be expedited as a decision rendered under the standard timeframe could jeopardize the patient's life, health (vision), or ability to regain maximum function. The physician's order MUST BE SUBMITTED to be considered urgent.