SuperiorVision®

Date of Request:

Routine Vision Services Authorization Request Form

Return fax to: 855-313-3106 (or secure e-mail to ecs@superiorvision.com) Phone: 888-273-2121

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

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.*

Do Not Use This Form For:

- Authorization Requests for Medical / Surgical Services
- Authorization Requests for Medicare Part B Drugs
- Authorization Requests for Benefit Eligibility Review

MEMBER INFORMATION:

Member Name: Date of Birth:

Member ID: Member's Health Plan:

RENDERING PROVIDER INFORMATION:

Rendering Provider Name: Rendering Provider Contact Name:

Rendering Provider NPI: Rendering Provider Contact Phone:

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:

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

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

New Prescription:

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

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

CONTACT LENSES PRESCRIPTION INFORMATION: **Dispensing Date**

OD: _____ 20/_____
SPHERE CYLINDER AXIS VISUAL ACUITIES

OS: _____ 20/_____
SPHERE CYLINDER AXIS VISUAL ACUITIES

KERATOMETRY READINGS

OD _____

OS _____

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 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.**