

Non-Elective (Medically Necessary) Contact Lenses Approval Request Form

Important: The following information is **required** for all requests. Please type or print clearly.

Date: _____ Subscriber ID# or SS#: _____
 Provider ID #: _____ Patient Name: _____
 Provider Name: _____ Patient Date of Birth: _____
 Address: _____ Subscriber Name: _____
 Phone: _____ Phone: _____
 Fax: _____ Address: _____

Please indicate the reason for this request (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Anisometropia
<input type="checkbox"/> Aphakia
<input type="checkbox"/> Astigmatism | <input type="checkbox"/> Hyperopia
<input type="checkbox"/> Keratoconus
<input type="checkbox"/> Myopia |
|--|---|

Additional Information: _____

Last exam Date: ____ / ____ / ____

Current Spectacle Rx:

	Sphere	Cyl	x	Axis	Prism	Base
Right:	_____	_____	x	_____	_____	_____
Left:	_____	_____	x	_____	_____	_____
Add:	R.E. _____	L.E. _____				

Best Corrected Spectacle Visual Acuity:

Distance _____	Near _____
Distance _____	Near _____

Keratometry Readings:

Right:	D/	_____	D X	_____
Left:	D/	_____	D X	_____

Grade of Mire Distortion:

O	+1	+2	+3	+4
O	+1	+2	+3	+4

Best Corr. VA w/Diagnostic CLs (if avail.):

Distance _____	Near _____
Distance _____	Near _____

Non-Elective (Medically Necessary) Contact Lenses Bilateral Right Only Left Only

Supplemental Eyewear (glasses): Other: _____

Contact Lens Fees:

Initial Exam: \$ _____	Materials: \$ _____
Follow-up visit(s): \$ _____	Fitting: \$ _____

CL Specifications:

Right: Base Curve: _____ mm	Diameter _____ mm	Power _____
Left: Base Curve: _____ mm	Diameter _____ mm	Power _____

Doctor/ Provider Signature

Date

Please forward this form with patient history, K-readings, Topography maps (if available), and any other applicable information to:

**Medical Eye Services
Benefit Resolutions Department
P.O Box 25209; Santa Ana, CA 92799**

Staff Use Only	Carrier: _____
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