

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):

- Anisometropia Hyperopia Aphakia Keratoconus Myopia Astigmatism

Additional Information:

Last Examination Date: ____/____/____

Current Spectacle Rx:

	Sphere	Cyl	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:

0 +1 +2 +3 +4
 0 +1 +2 +3 +4

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

Distance _____ Near _____
 Distance _____ Near _____

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's Signature

Date

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

**Vision Plan of America
 3255 Wilshire Blvd, Suite 1610
 Los Angeles, CA 90010
 or Fax To 213-3840084**

Staff Use Only: Approved Not Approved Medical Director's Signature: _____