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

The provider shall complete and submit this form and any other applicable information, such as the patient history, patient chart, K-readings, topography maps (if available), via email to qualitymanagement@eyemed.com, fax to (513) 492-3713, or by mail: EyeMed, Attn: Quality Management Department, 4000 Luxottica Place, Cincinnati, OH. 45040

Date:	Provider ID:	Subscriber ID or SSN:	
Provider Name:		Patient Name:	
Address:		Date of Birth:	
City, State, Zip:		Subscriber Name:	
Phone:	Fax:	Phone:	
Email:		Address:	
Contact Person:		City, State, Zip:	

Request Type: ☐ Retrospective _____Date lenses dispensed ☐ Prospective (lenses have not been dispensed)

Criteria for Medically Necessary (Non-Elective) Contact Lenses:

- ☐ Aphakia (after cataract surgery); A pair of single vision lenses or multi-focal lenses and frame may be provided with contact lenses;
- ☐ Keratoconus, i.e., when visual acuity cannot be corrected to 20/40 with the use of spectacles, or if other conditions indicate (please specify _____) (please include K readings or topography for approval);
- ☐ Anisometropia of 3.0 diopters or more, provided visual acuity improves to 20/60 or better in the weaker eye;
- ☐ Myopia of 12 diopters spherical equivalent or greater;
- ☐ Hyperopia of 7 diopters spherical equivalent or greater; or
- ☐ Astigmatism of greater than 3.0 diopters of cylinder.
- ☐ Other Conditions (i.e. various corneal findings) _____

Additional Information: _____

Date of Comprehensive Examination: _____ **Medically Necessary (Non-Elective) Contact**

Supplemental Eyewear (Glasses): _____ **Lenses:** ☒ Bilateral ☐ Right Only ☐ Left Only

Current Spectacle Prescription							Best Corrected Spectacle Visual Acuity	
	Sphere	Cylinder	Axis	Prism	Base	Add	Distance	Near
Right								
Left								

Keratometry Readings				Contact Lens Specifications					Best Corrected Visual Acuity w/CL	
				Power	Base Curve	Diameter	Cylinder	Axis	Distance	Near
Right										
Left										

Corneal Topography Submitted ☐ Yes ☐ No

Contact Lens Type: ☐ RGP ☐ Soft ☐ Scleral ☐ Hybrid ☐ Toric Lens ☐ Specialty Lens: _____

Contact Lens Fees:

Initial Exam: _____ **Materials:** _____

Follow-up Visits: _____ **Fitting:** _____

Brand _____

If Scleral or Hybrid, please submit charts or patient history that documents that Scleral or Hybrids are in the patient's best interest.

_____ Doctor / Provider Signature

_____ Date