DavisVision

Date of Request: _____

Routine and Medically Necessary Vision Services and Materials Authorization Request Form

Return to: Fax (800) 584-2329 or Secure Email to UMPAuth@versanthealth.com

Please check the specific health plan requirements for services that need a prior authorization. Not all services are covered by all plans.

Form must be fully completed, signed, and dated. Please include signed medical records with all requests (i.e., corneal topography, best corrected visual acuities). Failure to submit the required documentation may result in denied services.

Member Information

Member Name: _____ Date of Birth: _____

Primary Subscriber ID: _____ Member's Health Plan: _____

Rendering Provider Information

Rendering Provider Name: _____ Contact Name: _____

Individual Provider NPI: _____ Office Phone: _____

Rendering Provider Office ID: _____ Office Fax: _____

Office Address: _____

Services Being Requested: Date of Service: _____

CPT Code: _____ ☐OD ☐OS ☐OU Diagnosis Code(s): _____

CPT Code: _____ ☐OD ☐OS ☐OU Diagnosis Code(s): _____

CPT Code: _____ ☐OD ☐OS ☐OU Diagnosis Code(s): _____

Additional relevant information: _____

Health Conditions: Please select any applicable health conditions.

☐Diabetes ☐Hypertension ☐Cataracts ☐Cataract Surgery ☐Aphakia ☐Head/Neck Trauma ☐Kidney Disease ☐Pregnancy ☐Dementia

Other pertinent health conditions: _____

Is this request for two pair of single vision glasses in lieu of bifocals? ☐Yes ☐No
If yes, please submit medical documentation for the request.

Is this request for repair or replacement benefits? ☐Yes ☐No
If yes, please provide indication: _____

Eyeglass Prescription Information

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**
Provider's Signature						
Sign here:					Date:	

By checking the following box, you are certifying a decision rendered under the standard timeframe could jeopardize the patient's life, health (vision), or ability to regain maximum function and an expedited/urgent determination is required. This reason should not apply to routine services ☐
Medical indication for urgent request: _____

Determination: Authorization Number: _____