

Superior Vision Prior Authorization Request Submissions

June 2025



Our mission is to help members enjoy the wonders of sight through healthy eyes and vision.

Our purpose is grounded in the belief that when people can see everything, they hold the power to become anything they set their sights on—in their personal lives, in their communities, and in the world.

An illustration featuring a woman with dark hair in a bun, wearing a purple long-sleeved shirt and a dark skirt, running across a rooftop. In the background, a city skyline with various skyscrapers is visible under a soft, hazy sky. To the right, a multi-story building has several balconies. On the top balcony, a man in a red tank top and shorts waves. On a middle balcony, a woman in a pink dress and a face mask looks out. On the bottom balcony, a man in a white t-shirt and blue shorts is exercising with weights, and a woman in a red top and pants is also exercising. A large teal banner with white text is positioned in the lower right area of the image.

**SEE EVERYTHING.
BE ANYTHING.™**

Agenda

- Revised Forms
- General Information
- Medical Necessity Reviews
- Benefit Reviews
- Submitting the Prior Authorization Form
- Commonly Seen Errors



Revised Forms

Top Portion of Routine/Medically Necessary Services and Materials Form

- Revised forms are now available on the Provider Resource Center (PRC) (prc.versanthealth.com/forms)
- Revisions to the top portion of the form seen here include individual provider NPI and laterality of CPT code selection with corresponding diagnosis code
- The fields outlined in red are required for processing a prior authorization request



Date of Request:

Routine and Medically Necessary Vision Services and Materials Authorization Request Form
Return to: Fax (855) 313-3106 or Secure Email to ecs@superiorvision.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:
Member ID: Member's Health Plan:

Rendering Provider Information

Rendering Provider Name: Contact Name:
Individual Provider NPI: Office Phone:
Rendering Provider Tax 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:

Revised Forms Continued

Bottom Portion of Routine/Medically Necessary Services and Materials Form

- Revisions include pertinent health conditions and specific requested benefit reviews including repair or replacement benefits
- Repair or Replacement benefits include broken and lost glasses

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 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:

Revised Forms Continued

Medical / Surgical Prior Authorization Request Forms

- Individual Provider NPI, minor formatting changes

Medical/Surgical Prior Authorization Request Form

Return fax to: 855-313-3106 (or secure email to ecs@superiorvision.com)

Date of Request:

<u>Patient Information:</u> Patient Name: <input type="text"/> Member ID: <input type="text"/> Date of Birth: <input type="text"/> <u>Other Primary Insurance Information:</u> Health Plan Name: <input type="text"/> Health Plan Product: <input type="text"/> Medicare primary? <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Provider Information:</u> Rendering Provider Name: <input type="text"/> Individual Provider NPI: <input type="text"/> Rendering Tax ID: <input type="text"/> Rendering Provider Address: <input type="text"/> Contact Name: <input type="text"/> Phone Number: <input type="text"/> Fax Number: <input type="text"/>															
<ul style="list-style-type: none"> • Please include medical records with all requests. • Legible clinical notes within the last six months are required. • Medical records must be signed and finalized. 																
<u>Requested Services:</u> Date of Service: <input type="text"/> <table> <tr> <td>CPT: <input type="text"/></td> <td><input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU</td> <td>Diagnosis Code(s): <input type="text"/></td> </tr> <tr> <td>CPT: <input type="text"/></td> <td><input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU</td> <td>Diagnosis Code(s): <input type="text"/></td> </tr> <tr> <td>CPT: <input type="text"/></td> <td><input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU</td> <td>Diagnosis Code(s): <input type="text"/></td> </tr> <tr> <td>CPT: <input type="text"/></td> <td><input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU</td> <td>Diagnosis Code(s): <input type="text"/></td> </tr> <tr> <td>CPT: <input type="text"/></td> <td><input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU</td> <td>Diagnosis Code(s): <input type="text"/></td> </tr> </table> Facility/Office Name: <input type="text"/> Facility/Office Phone Number: <input type="text"/> Circle Facility Type: <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> IN OFFICE <input type="checkbox"/> ASC <input type="checkbox"/> EMERGENCY ROOM		CPT: <input type="text"/>	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	Diagnosis Code(s): <input type="text"/>	CPT: <input type="text"/>	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	Diagnosis Code(s): <input type="text"/>	CPT: <input type="text"/>	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	Diagnosis Code(s): <input type="text"/>	CPT: <input type="text"/>	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	Diagnosis Code(s): <input type="text"/>	CPT: <input type="text"/>	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	Diagnosis Code(s): <input type="text"/>
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CPT: <input type="text"/>	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	Diagnosis Code(s): <input type="text"/>														
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 <input type="checkbox"/> Medical indication for urgent request: <input type="text"/>																

General Information

➤ Individual provider NPI

- Prior authorizations are issued for network providers based on the provider and location. Each network provider has an individual provider NPI. To ensure each prior authorization is associated with the appropriate network provider, the individual provider's NPI is needed in lieu of umbrella office NPIs.
- Medical necessity requests must be supported by documentation from the treating healthcare professional that is requesting medical necessity (i.e. OD or MD)

➤ Office Address

- The office address ensures a prior authorization is issued to the provider's correct location and does not delay claims processing

➤ Laterality of Requested CPT Codes

- Laterality is pertinent information for clinical reviewers to complete medical necessity reviews.

➤ Date of Service

- Each form is valid for one date of service. If a prior authorization is needed for CPT codes on additional dates of service, please submit a new form for each date of service.

Routine Medical Necessity Reviews

Required Processing Elements

- Member Demographics
 - Member Name
 - Member Date of Birth
 - Member ID
- Provider Information
 - Provider's Name
 - Individual Provider's NPI
 - Office Address
 - Office Phone and Fax Number
- Requested Services or Materials
 - CPT codes
 - Laterality
 - Diagnosis Codes
 - Single Date of Service (if unknown or undecided, leave blank)
- Clinical Information
 - Complete Medical Records (including but not limited to)
 - Complete Eye Exam
 - Color topography
 - Keratometry
 - Complete Eye Exam
 - Best Corrected Visual Acuity with Eyeglasses and Contact Lenses
- Provider Signature and Date

Benefit Reviews

Required Processing Elements

- Member Demographics
 - Member Name
 - Member Date of Birth
 - Primary Subscriber's ID (policy holder)
- Provider Information
 - Provider's Name
 - Individual Provider's NPI
 - Office Address
 - Office Phone and Fax Number
- Clinical Information Relevant to the Request
 - New and Old Prescription
 - Indication for repair/replacement benefits (i.e lost, broken, etc.)
- Requested Services or Materials
 - CPT codes
 - Laterality
 - Diagnosis Codes
 - Single Date of Service (if unknown or undecided, leave blank)
- Provider Signature and Date

Medical Surgical Reviews

Required Processing Elements

- Member Demographics
 - Member Name
 - Member Date of Birth
 - Subscriber's ID
- Provider Information
 - Provider's Name
 - Individual Provider's NPI
 - Office Address
 - Office Phone and Fax Number
- Clinical Information Relevant to the Request, for example:
 - Clinical examination notes
 - ADLs
 - Manifest Refraction with Best Corrected Vision
 - Rationale for Complex Cataract Surgery
 - Gonioscopy of all 4 quadrants
- Current list of glaucoma medications
- Color photographs of both eyelids
- Visual field - taped and untaped
- Requested Services or Materials
 - CPT codes
 - Laterality
 - Diagnosis Codes
 - Single Date of Service (if unknown or undecided, leave blank)
- Provider Signature and Date

Submitting the Prior Authorization Form

- The first step in submitting a prior authorization request is submitting the correct prior authorization form
 - Superior Vision Routine and Medically Necessary and Medical Surgical Prior Authorization Request Forms are on the Provider Resource Center (PRC) (prc.versanthealth.com/forms)
 - Complete all required fields previously noted
 - Submit prior authorization form with all relevant clinical information by email to ECS@superiorvision.com or by fax at (855) 313-3106
 - Arizona and New Mexico Universal Prior Authorization Request Forms are on the Provider Portal
 - Form should be completed and submitted with all relevant clinical information by email to ECS@superiorvision.com or by fax at (855) 313-3106
- Accessing the prior authorization form from the PRC
 - prc.versanthealth.com
 - Resources
 - Prior Auth Forms
 - [Superior Vision Routine & Medically Necessary Services Prior Authorization Request Form 2024](#)
 - [Superior Vision Medical Surgical Prior Authorization Form 2024](#)

Commonly Seen Errors

Unable to Process

- Missing requested services
 - All requests require CPT codes and diagnosis codes
- Unable to verify provider
 - Provider name, NPI, and address assist verify provider and location
- Multiple member requests in one submission
 - Each request creates a case file for an individual member, multiple member requests should be submitted separately
- Multiple dates of service in one request
 - Each date of service requires a separate prior authorization and should be submitted separately
- Open authorization on file for the same requested services
 - The provider portal may be utilized to verify if a member has an open authorization on file
- Denial on file for the same requested services
 - Previously denied services within the last 60 days must follow the appeals process outlined in the denial letter notice
- Duplicate requests
 - Requests only need to be submitted once by either email or fax, not both, to avoid inadvertent void of both requests
- Claims Submissions
 - The UM department is unable to process claims. Contact provider services at (800) 773-2847 for assistance in submitting a claim.

Q & A

Additional questions or status checks related to prior authorizations can be submitted via email at ecs@superiorvision.com or by contacting the Superior Vision Utilization Management Department at (888) 273-2121



SuperiorVision®

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