EYE SERVICES
PRIOR APPROVAL REQUEST
CONTACT LENSES

PATIENT INFORMATION

Name	ID Number	Sex ☐ M ☐ F	Date of Birth
Street Address			
City	State		Zip Code

Provider	Ordering Physician's Name, Address, Zip Code

USE SNELLEN NOTATION

Prior Rx Date		VA with Old Rx	VA No Rx		NEW Rx Date		Corrected VA
Distance	R	R	R		Distance	R	R
	L	L	L			L	L
Near or Add	R	R	R		Near or Add	R	R
	L	L	L			L	L

COMMENTS/JUSTIFICATIONS

Pair of contact lenses	Diagnosis of keratoconus of ±3.00 of anisometropia or a correction of ±6.00 diopters
Single contact lenses	Monocular aphakia

Date of Exam	Provider Name	Provider Signature

RECOMMENDATIONS

Date	Reviewer