**Prior Authorization Form**

**Vermont Medicaid Eyeglass Program**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Beneficiary Unique Vermont Number** | | | | | | | |  | **Date of Birth (MM/DD/YYYY)** | | |  | **Gender** |
|  |  |  |  |  |  |  |  |  |  |  |  |  | M/F |

**Patient Name:**

**(Last, First, MI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Old Rx - Date \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_ | | | |  | New Rx - Date \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_ | | | |
|  | Sphere | Cyl | Axis |  |  | Sphere | Cyl | Axis |
| OD |  |  |  |  | OD |  |  |  |
| OS |  |  |  |  | OS |  |  |  |
| ADD |  |  |  |  | ADD |  |  |  |

**Provider Name:**

**(Last, First, MI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| V | Frame (RA) |
| V | Lens (RT) (RA) |
| V | Lens (LT) (RA) |
| V | Frame  (non-replacement) |
| V | Lens (RT) |
| V | Lens (LT) |
| V |  |

**Please note: Any replacement (frame and/ or lens) requires a RA modifier**

**Classic Optical Provider Number – 1020469**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Provider NPI Number** | | | | | | | | | | | | | | | | **Vermont Provider Number** | | | | | | | | | | |
|  |  | |  | |  | |  |  |  | |  | |  | |  |  |  | |  |  |  |  |  |  |  |  |
| **Classic Optical Account Number** | | | | | | | | | | | | | | | | **Provider Office Name** | | | | | | | | | | |
|  | |  | |  | |  | |  | |  | |  | |  | |  | | | | | | | | | | |
| **Provider Address** | | | | | | | | | | | | | | **Telephone Number** | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| **City** | | | | | | | | | | | | | | | | **State** | | **Zip** | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Diagnosis codes are now required. See page 2**

Medically Necessary (see page 2 to provide documentation)

Replacement for Scratched lenses – visual acuity compromised

Replacement for change in Rx by at least one-half diopter in a single lens

Replacement within 24 months, not lost or broken

Outgrown frame

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The diagnosis code must be specific to laterality, such as right eye, left eye, or both eyes. Unspecified eye, eyelid, lacrimal gland, side or lacrimal passage etc. are not allowed and claim will deny.**

**Please check appropriate diagnosis code for order:**

**H52.03 Hypermetropia, bilateral**

**H52.13 Myopia, bilateral**

**H52.31 Anisometropia**

**H52.4 Presbyopia**

**H52.7 Unspecified disorder of refraction**

**V45.61 status post cataract extraction**

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Please provide the clinical information to support medical necessity. (Include additional pages if necessary.)** |
|  |