VERMONT

State of Vermont
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Agency of Human Services

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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 _____/ _____/ _____			
	Sphere	Cyl	Axis
OD			
OS			
ADD			

New Rx - Date _____/ _____/ _____			
	Sphere	Cyl	Axis
OD			
OS			
ADD			

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

Provider Name:
(Last, First, MI) _____

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**
Ordering Provider Signature	**Date (MM/DD/YYYY)**

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: _____

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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.)