

# MEDICAL PRE-AUTHORIZATION REQUEST FORM

\_\_\_\_\_ ROUTINE

\_\_\_\_\_ URGENT \*

**\*A physician with knowledge of the patient's medical condition must determine it a case involving urgent care and that use of non-urgent timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or, based on the physician's opinion, the member would be subjected to severe pain. NOTE: Urgent requests MUST be accompanied by a signed physician's order.**

Date \_\_\_\_\_ Office Contact \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Attending Physician \_\_\_\_\_ NPI# \_\_\_\_\_

Patient Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ DOB \_\_\_\_\_

ID # \_\_\_\_\_ HMO (Plan) \_\_\_\_\_ Group # \_\_\_\_\_

Other Insurer (if any) \_\_\_\_\_

Date of Admit \_\_\_\_\_ Date of Surgery \_\_\_\_\_ IP/OP (Circle One) Anticipated LOS \_\_\_\_\_

Facility Name & Address \_\_\_\_\_

Facility Status: PAR NON-PAR Reason for Non-Par Request: \_\_\_\_\_

| Diagnosis (must be provided) | Procedure (must be provided) | Circle (appropriate eye(s)) |
|------------------------------|------------------------------|-----------------------------|
| ICD _____ Description _____  | CPT _____ DESCRIPTION _____  | RT LT 50                    |
| ICD _____ Description _____  | CPT _____ DESCRIPTION _____  | RT LT 50                    |
| ICD _____ Description _____  | CPT _____ DESCRIPTION _____  | RT LT 50                    |

Medical Reason for Request \_\_\_\_\_

Attach additional pages if necessary

Patient's Subjective Complaint \_\_\_\_\_

Patient's BCVA OD \_\_\_\_\_ OS \_\_\_\_\_

Target Refraction OD \_\_\_\_\_ OS \_\_\_\_\_

**A comprehensive ophthalmic evaluation, including manifest refraction documenting the medical necessity for cataract surgery must be completed no longer than three months prior to surgery.**

Signature of Attending Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Office Address: \_\_\_\_\_

**PRE CERTIFICATION/AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. COVERED SERVICES ARE BASED ON MEMBER ELIGIBILITY AND BENEFIT LIMITATIONS AT THE TIME SERVICE(S) ARE RENDERED.**

**PLEASE FAX YOUR REQUEST TO: (877) 865-1077 OR MAIL TO:  
OPTICARE MANAGED VISION, INC, ATTN: MEDICAL MANAGEMENT, PO BOX 7548, ROCKY MOUNT, NC 27804**

**If denied, please refer to your Provider Manual or call (800) 465-6972 to be informed of your appeal rights.**

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