Low Vision Benefit Request & Review Form

Please submit this form with the patient history and/or any other applicable information via email to benefitresolutions@mesvision.com, fax to (714) 619-4668, or by mail: Medical Eye Services, Attn: Benefit Resolutions Department, P.O. Box 25209, Santa Ana, CA 92799.

Date: _____ Provider ID: _____		Subscriber ID or SSN:	
Provider Name:		Patient Name:	
Address:		Date of Birth:	
City, State, Zip:		Subscriber Name:	
Phone: _____ Fax: _____		Phone:	
Email:		Address:	
Contact Person:		City, State, Zip:	

Request: ☐ Low Vision Evaluation ☐ Low Vision Aid(s) ☐ Low Vision Follow Up & Training

Criteria for Low Vision (best corrected visual acuity (BCVA) in the better eye):

- ☐ Moderate: BCVA is 20/70 or less
- ☐ Severe: BCVA is 20/200 or less (legal blindness), or visual field is 20 degrees or less
- ☐ Profound: BCVA is 20/400 to 20/1000, or visual field is 10 degrees or less
- ☐ Hemianopsia (with or without macular sparing)

Note: The patient history and/or supporting documentation must demonstrate functional and/or quality of life improvement.

Date of Comprehensive Examination (within last 6 months): _____

Date of Last Low Vision Evaluation (and training), if applicable: _____

Diagnosis Codes (ICD-10): _____

Best Corrected Visual Acuity:
Right: Distance _____/_____ Near _____/_____
Left: Distance _____/_____ Near _____/_____

Visual Field (Degrees):
(when applicable to the diagnosis)
Right: _____ **Left:** _____

Low Vision Aid(s) Proposed (catalog price sheets/invoices are required for each proposed aid)	**Wholesale Cost**	**Provider's U&C**

_____ Doctor / Provider Signature

_____ Date

MES*Vision*® Staff Use Only

Date Received:		Prepared By:	
Case Number:		Claim Number:	
Carrier Name:		Carrier Type:	
Previously Approved:	☐ Yes ☐ No	Date of Last Approval:	

DETERMINATION (if pended or denied, please provide a brief explanation): **Pend** ☐ **Approved** ☐ **Denied** ☐

_____ Medical Director / Clinical Director Signature

_____ Date