Non-Elective (Medically Necessary) Contact Lenses
Approval Request Form

The provider shall complete and submit this form and any other applicable information, such as the patient history, patient chart, K-readings, topography maps (if available), 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. Phone assistance is available at (800) 877-6372.

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 Type: ☐ Retrospective _____ Date lenses dispensed ☐ Prospective (lenses have not been dispensed)

Criteria for Non-Elective (Medically Necessary) Contact Lenses:

☐ Aphakia (after cataract surgery); A pair of single vision lenses or multi-focal lenses and frame may be provided with contact lenses;
☐ Keratoconus, i.e., when visual acuity cannot be corrected to 20/40 with the use of spectacles, or if other conditions indicate (please specify _____) (please include K readings or topography for approval);
☐ Anisometropia of 3.0 diopters or more, provided visual acuity improves to 20/60 or better in the weaker eye;
☐ Myopia of 12 diopters spherical equivalent or greater;
☐ Hyperopia of 7 diopters spherical equivalent or greater; or
☐ Astigmatism of greater than 3.0 diopters of cylinder.
☐ Other Conditions (i.e. various corneal findings) _____

Additional Information: _____

Date of Comprehensive Examination: _____ **Non-Elective (Medically Necessary) Contact Lenses:**

Supplemental Eyewear (Glasses): _____ ☐ Bilateral ☐ Right Only ☐ Left Only

Current Spectacle Prescription							Best Corrected Spectacle Visual Acuity	
	Sphere	Cylinder	Axis	Prism	Base	Add	Distance	Near
Right								
Left								

Keratometry Readings				Contact Lens Specifications					Best Corrected Visual Acuity w/CL	
				Power	Base Curve	Diameter	Cylinder	Axis	Distance	Near
Right										
Left										

Corneal Topography Submitted ☐ Yes ☐ No

Contact Lens Type: ☐ RGP ☐ Soft ☐ Scleral ☐ Hybrid ☐ Toric Lens ☐ Specialty Lens: _____

Contact Lens Fees:

Initial Exam: _____ **Materials:** _____

Follow-up Visits: _____ **Fitting:** _____ Brand _____

If Scleral or Hybrid, please submit charts or patient history that documents that Scleral or Hybrids are in the patient's best interest.

_____ Doctor / Provider Signature

_____ Date

MES*Vision*® Staff Use Only			
Date & Time Received:	_____	Prepared By:	_____
Case Number:	_____	Claim Number:	_____
Carrier Name:	_____	Carrier Type:	_____