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

Staff Use Only:
Case# _____

Date: _____ Provider ID#: _____

Provider Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

Contact: _____

Subscriber ID # or SS#: _____

Patient Name: _____

Date of Birth: _____

Subscriber Name: _____

Phone: _____

Address: _____

City, State, Zip: _____

To be completed by the DOCTOR making this request.
Please indicate the reason for this request (check all that apply), all information is required:

☐ **Anisometropia** of 3.0 diopters or more, provided visual acuity improves to 20/60 or better in the weaker eye.

☐ **Aphakia** (after cataract surgery); A pair of single vision lenses or multi-focal lenses and frame may be provided with the contact lenses.

☐ **Astigmatism** of greater than 3.0 diopters of cylinder.

☐ **Hyperopia** of 7 diopters spherical equivalent or greater

☐ **Keratoconus**, i.e., when visual acuity cannot be corrected to 20/40 with the use of spectacles, or if other conditions indicate (please include K readings or topography for approval)

☐ **Myopia** of 12 diopters spherical equivalent or greater

Additional Information: _____
Last Exam Date: _____

Current Spectacle Rx:

	Sphere	Cyl		Axis	Prism	Base
Right:	_____	_____	X	_____	_____	_____
Left:	_____	_____	X	_____	_____	_____

Add: R.E. _____ L.E. _____

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

Keratometry Readings:
Right: _____ D/ _____ D X _____
Left: _____ D/ _____ D X _____

Best Corr. VA w/Diagnostic CLs (if avail.):
Distance _____ Near _____
Distance _____ Near _____

Non-Elective (Medically Necessary) Contact Lenses ☐ Bilateral ☐ Right Only ☐ Left Only

Supplemental Eyewear (Glasses): ☐ Other: _____

Contact Lens Fees: Initial Exam: $_____ Materials: $_____
Follow-up visit(s): $_____ Fitting: $_____

CL Specifications: ☐Hard ☐Soft
Right: Base Curve: _____ mm Diameter _____ mm Power _____
Left: Base Curve: _____ mm Diameter _____ mm Power _____

_____ _____
Doctor / Provider Signature **Date**

Please forward this form with patient history, K-readings, Topography maps (if available), and or any other application information:

Mail: Medical Eye Services
Benefit Resolutions
P.O. Box 25209; Santa Ana, CA 92799

Fax: (714) 619-4668
E-Mail: benefitresolutions@mesvision.com
Phone Assistance: (800) 877-6372

MESVision Staff Only

Case Received via ☐**Mail** ☐**Fax** ☐**E-mail** ☐**Phone Call** **Doctor to Fill Clinical Portion of this Form** ☐**Yes** ☐**Completed**

Call Received By: _____ Date: _____ Date to Doctor to Enter Clinical Data: _____

MESVision Rep Date Received From Doctor with Clinical Data: _____