Instructions for submitting the

Vision Medically Necessary Contact Lens Request Form

This form may be completed on your computer; tab through the fields and enter all requested information.

To help facilitate a quick response to your request:

- ✓ Save the form to your computer
- ✓ Complete **ALL** information
- ✓ Save final copy
- ✓ Print the completed form
- ✓ Fax the form to 949.389.9708

If you prefer, you can mail the completed form to:

SafeGuard
Vision Medically Necessary Contact Lens Request
5 Park Plaza, Suite 1850
Irvine, CA 92614

If you have any questions about this form or how to submit, please contact Provider Services at 800.635.4238

SafeGuard®

VISION

MEDICALLY NECESSARY CONTACT LENSES AUTHORIZATION REQUEST

Fax: **949.389.9708**

To request an authorization for Medically Necessary Contact Lenses, please submit a completed form to SafeGuard's Claims Department. This form has form fields and can be filled out electronically. Remember to keep a copy for your files.

Doctor & Patient Information:			
Doctor Name:			SafeGuard Provider ID:
Address:			
City:	State:	ZIP:	Telephone:
Authorization Number:			Group Number I.D.:
Patient First Name:			Patient Last Name:
SafeGuard Member I.D.:			Patient D.O.B (MM/DD/YYYY):

I request permission to use contact lenses for the above-mentioned SafeGuard Patient for the following reason(s):

- ☐ Patient has had cataract surgery resulting in aphakia. Indicate date of surgery: _____
- ☐ Patient has extreme visual acuity problems that cannot be corrected to 20/70 in the better eye with spectacle lenses.
- ☐ Patient has Anisometropia of 4.00 diopters or more and contact lens correction will improve visual acuity to 20/70 or better in the poorer eye.
- ☐ Patient has Keratoconus. (Must include Keratometry readings and descriptions or grading of mires.)

Note: The narrowing of visual fields due to high minus or plus corrections is not considered a reason for medically necessary contact lenses.

PATIENT'S SPECTACLE PRESCRIPTION IS:

	SPHERE	CYLINDER	AXIS	PRISM	BASE	K READING	MIRES
RIGHT EYE							
LEFT EYE							
READING ADD	**RIGHT EYE:**		**LEFT EYE:**				

C.L. Fitting is: ☐ First time ☐ Replacement ☐ Binocular ☐ R ☐ L

BEST SPECTACLE CORRECTED VISUAL ACUITY

DIST		NEAR	
R	L	R	L

Type of Contact Lenses Prescribed

Rigid	Soft	Hybrid
☐ RGP Sphere ☐ RGP Toric ☐ PMMA Sphere ☐ PMMA Toric	☐ Soft Sphere ☐ Toric Sphere ☐ Other:	☐ SoftPerm® ☐ Synergeyes®

Usual & Customary Charges:
Comprehensive Exam: _____ Fitting/Evaluation: _____ Materials: _____

ICD-9-CM Diagnosis Code: _____

Signature of Examining Doctor: _____ Date: _____

For SafeGuard Vision Use Only

CA		TX / FL / NV	
For Plans: A, B, C, D STD A, B, C, D Plus I, II, III, IV, PacAdv Plus PacAdv Pref PacAdv II 10 Plus FlexChoice II CalKid $500	Provider's UCR Fee: _____ less 20%: _____ Amount Approved (not to exceed 80% UCR) _____ less MNCL Allowance: (250.00) **Amount Charged to Member:** _____	For Plans: V Plans VP Plans HA Plans Option 8 and 9 SHV Plans	Provider's UCR Fee: _____ less MNCL Allowance: (250.00) Subtotal: _____ less 15%: _____ **Amount Charged to Member:** _____
For Plans: V Plans VP Plans Image PPO HA Plans	Provider's UCR Fee: _____ less MNCL Allowance: (250.00) **Amount Charged to Member:** _____	TX Only: Commercial Grp	Provider's UCR Fee: _____ less MNCL Allowance: (250.00) **Amount Charged to Member:** _____

Approved by: _____ Date: _____
SafeGuard Vision Director