Medical Authorization Request Form

SuperiorVision®

Return fax to (855) 313-3106 (or secure email to ecs@superiorvision.com)

Please submit authorization forms for different dates of service and individual members as separate requests.

Patient Info:

Patient Name: _____

Member ID: _____

DOB: _____

Member's Primary Care Site (if applicable): _____

Referring Physician Name: _____

Referring Physician Healthplan ID: _____

Contact Name: _____

Contact Phone # : _____

Provider Info:

Date of Request: _____

Rendering Provider NPI: _____

Rendering Provider Name: _____

Correspondence Address: _____

_____

Rendering Provider Healthplan ID: _____

Contact Fax #: _____

Other Primary Insurance Information:

Health Plan Name: _____ Medicare primary? ☐ **Yes** OR ☐ **No** (select one)

Health Plan Product: _____

OD	**OS**
Diagnosis: _____	Diagnosis: _____
Diagnosis Code(s): _____	Diagnosis Code(s): _____
_____	_____

Please include medical records with all requests. Failure to submit the required documentation may result in a denial.

Cataract surgery: ADL Form/Documentation, Manifest Refraction with BCVA, Anterior and Posterior Segment Exam

YAG Capsulotomy: ADL Form, Manifest Refraction with BCVA, Anterior and Posterior Segment Exam

LPI: Diagnosis (ex. Acute, Subacute, Intermittent, or Chronic Angle Closure Glaucoma), Gonioscopy Findings, Statement of occludable, occludable narrow angle, or occluded angle

SLT: Diagnosis (ex POAG), Target IOP, Clinical Exam, Laser Trabeculoplasty Log if available, Testing (OCT NFL, Visual Fields)

Blepharoplasty: Color Photos front and oblique, Symptoms, ADL affected, MRD, Visual field if available

Medically Necessary Contact Lenses: Please do not use this form. Please use the Routine Vision Services Authorization Request form.

Requested Procedure Information (Please select one): ☐ OD ☐ OS ☐ OU

CPT Codes (1-6): _____ _____ _____ _____ _____ _____

Date of Service _____ Facility/Office Name _____

Facility/Office Address _____ Facility/Office Phone # _____

Facility Type (Select One): ☐ **OUTPATIENT** ☐ **IN OFFICE** ☐ **ASC** ☐ **EMERGENCY ROOM**

Drug Code (Select One): ☐ **J0178** ☐ **J0179** ☐ **J0585** ☐ **J2503** ☐ **J2778** ☐ **J3396** ☐ **J7312** ☐ **J7313** ☐ **J7314**

☐ **J7316** ☐ **J3490** ☐ **J3590** ☐ **J9035** **Note:** All requests for the J codes must follow Healthplan protocols.

☐ **Urgent**: By checking this box, you are **certifying** the physician has ordered that the request be **expedited** as a decision rendered under the standard timeframe could jeopardize the patient's life, health (vision), or ability to regain maximum function. **The physician's order MUST BE SUBMITTED to be considered urgent.**