MARCH® Vision Care GROUP INCORPORATED

Medically Necessary Contacts Pricing Request Form

Contact Name: _____

Contact Telephone Number: _____

Contact Email Address: _____

Rendering Provider: _____

Tax ID Number: _____

Member Name: _____

Member ID: _____

Confirmation Number: _____

Date of Service: _____

Diagnosis: _____

Diagnosis Code(s): _____

CPT Code and requested reimbursement rate for each code

RT: CPT Code:_____Reimbursement Rate:_____Qty:_____

LT: CPT Code:_____Reimbursement Rate:_____Qty:_____

CL Fit: CPT Code:_____Reimbursement Rate: _____

Type/Brand of lenses prescribed: _____

RT: Base Curve_____Diameter_____

LT: Base Curve_____Diameter_____

Please attach a copy of the patient's examination chart and fax your completed form to Network Solutions at (877)627-2488 or email it to providers@marchvisioncare.com.