Medically necessary contacts pricing request form

Contact, provider and member information

Contact name: _____ Telephone #: _____ Email address: _____

Provider name: _____ Tax ID #: _____

Member name: _____ Member ID: _____ Confirmation #: _____

Date of service: _____ Diagnosis: _____ Diagnosis code(s): _____

Request type: ◯ Retrospective – Date lenses dispenses: _____ ◯ Prospective (lenses not dispensed)

Criteria for medically necessary (non-elective) contact lenses

The prescribing provider determines if non-elective contact lenses are covered based on criteria provided by the member's benefit plan and the UnitedHealthcare | March Vision Care state-specific plan benefits and requirements.

Please indicate primary diagnosis for the request of medically necessary contact lenses:

- ☐ Keratoconus – visual acuity cannot be corrected to 20/40 with the use of eyeglasses *(please submit topography)*
- ☐ Aphakia
- ☐ Anisometropia greater than 3.0 diopters
- ☐ Myopia of 12 diopters spherical equivalent or greater
- ☐ Hyperopia of 7 diopters spherical equivalent or greater
- ☐ Other conditions (i.e. various corneal findings) _____

Corneal topography submitted *(required for members with corneal disorders, such as Keratoconus)*: ◯ Yes ◯ No

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: _____

Brand of lenses prescribed: RT: _____ LT: _____

Type of lenses prescribed: ◯ RGP ◯ Soft ◯ Scleral* ◯ Hybrid* ◯ Toric lenses

**If scleral or hybrid is selected, please indicate in submitted charts/records that scleral or hybrid are in the patient's best interest.*

Provider signature: _____ Date: _____

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.