

Vision Prior Authorization Request

Idaho Medicaid Medical Care
 PO Box 83720
 Boise, ID 83720-0036
 Phone: **(208) 364-1839**
 Fax: **(208) 332-7280**

For Department Use Only

PA Number: _____

Reviewed By: _____

Review Date: _____

Provider Name: _____

Provider Number: _____ Phone Number: _____ Fax Number: _____

Participant Name: _____ Date of Birth: _____

Participant Medicaid Number: _____ Date of Service: _____

Service/Procedure Code Requested For Review:

High Index Lens Procedure Code: _____ Aspheric Lens Procedure Code: _____

Contact Lens Procedure Code: _____ Quantity (exact number of contact lenses per eye x 1 year) _____

Specialty Frame Procedure Code: _____ Early Exam Procedure Code: _____

Lenticular Lens Procedure Code: _____ Other Procedure Code: _____

Please consult your *Provider Handbook* and include all appropriate documentation with requests for procedures or equipment not listed above.

Indicate Current RX Below						
Current Rx		Spherical	Cylindrical	Axis	Prism	Base
D.V.	O.D.					
	O.S.					
N.V.	O.D.					
	O.S.					

If RX changed: Indicate previous RX below and date of service:

Note: If change is glasses to contacts provide old and new glasses RX. If change is contacts to glasses provide old and new contact RX.

Indicate Previous RX Below						
Rx Date:		Spherical	Cylindrical	Axis	Prism	Base
D.V.	O.D.					
	O.S.					
N.V.	O.D.					
	O.S.					

Justification, if applicable: Broken ___ Lost ___ Out Grown ___ Vision Change ___

Other: _____
