Neighborhood Health Plan OF RHODE ISLAND™

Vision Care
Prior Authorization Form

Please return completed form to the Utilization Management Department at (401)459-6023.

Please refer to Neighborhood's *Clinical Medical Policy* which is available on our Neighborhood web site, www.nhpri.org for more detailed information about this benefit, authorization requirements, and coverage criteria.

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
PROVIDER INFORMATION		
Provider's Name:	Supplier ID or NPI #:	Date of Request:
Provider's Group Name:	Previous Auth #:	Date of Service:
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:

CLINICAL INFORMATION

The test must be for the benefit of the member in that the test results will have an impact on and make a change in the member's clinical management. The sensitivity of the test must be greater than the clinical pre-test probability of the diagnosis.

CPT Code:	Units:	CPT Code:	Units:

Diagnosis:	**Diagnosis Code:**

❑ Progressive Lenses	Rationale _____
❑ Polycarb Lenses for Adults	Rationale _____
❑ Polychromic Lenses	Rationale _____
❑ Other Request	Rationale _____

SERVICES REQUESTED INSTRUCTIONS: Please select requested service and check YES or NO.

❑ Replacement lenses age 21 years old and over. (Eyeglass frames are covered only every 2 years.)	Change in refraction of at least 0.5 diopter (lens spherical equivalent)	Yes ❑ No ❑
❑ High Index Lenses	Prescription is (-10) or above and lens does not fit into frame.	Yes ❑ No ❑
❑ Punctal Plugs (Please respond to both 1 & 2)	1) History of using artificial tears without success 2) Trial use of collagen plugs which dissolve in 7-12 days with success, i.e. symptom relief	Yes ❑ No ❑ Yes ❑ No ❑
❑ Contact Lenses (Please select any that apply)	1) High myopia (> -6.00) 2) Keratoconus that cannot be corrected with glasses. 3) Anisometropia with diopter difference > 3. (Difference in the power of required lens power of the two eyes of greater than a spherical equivalent of 3 diopters.) 4) Aphakic Contact lens for aphakia	Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No ❑

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN

Signature of Treating Physician:	**Date:**

NEIGHBORHOOD DECISION - Authorization is not a guarantee of payment.

Authorization #:	Dates of Service	Services Approved:
UM Initials:	Notification Date:	❑ Not Approved - Letter to Follow

Updated 7/2011, 7/2012, Reviewed 6/2013 , updated 2/2016