Low Vision Verification

Use this form to request low vision evaluation and aids. Refer to the Plans and Coverages section in the VSP® Manual on VSPOnline for requirements and limitations.

Doctor NPI _____

Doctor Name _____

Address _____

City, State, Zip _____

Phone (_____) _____

Fax (_____) _____

Office Staff Contact Name _____

Date of Service _____

Member ID (or last four of SSN) _____

Authorization Number _____

Patient Name _____

Patient Date of Birth _____

Member Name _____

Member Date of Birth _____

Member Address _____

_____

Request is for

❑ Low Vision Evaluation – U&C fee for proposed evaluation $_____

❑ Low Vision Aids

Patient's Diagnoses

Indicate the patient's low vision diagnosis.

Diagnosis Code 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Best Corrected Visual Acuity

RIGHT: Dist _____ /_____ Near _____ /_____ **LEFT:** Dist _____ /_____ Near _____ /_____

Complete this section for Low Vision Aids proposed

(Catalog price sheets or invoices required for each aid to support the wholesale cost listed.)

Low Vision Aid	Model #	Mon/ Bin	Visual Acuity	Patient Use of Aid	Wholesale Cost	Doctor's U&C
		M B				
		M B				
		M B				
		M B				
		M B				
		M B				

Please fax this form to **916.851.4733** or mail to
VSP Vision, Attention: Claim Services, PO Box 495907, Cincinnati, OH 45249-5907.

IMPORTANT: Forms received with missing or incomplete information won't be processed.