vsp vision care

Materials Verification

Refer to the **Plans and Coverages** section in the **VSP® Manual** on **VSPOnline** for requirements and limitations. If limitations prevent submission through Eyefinity®, use this form to request necessary contact lenses.

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 ______________________

____

Necessary Contact Lenses (Mark Reason)

- ❑ Aniridia
- ❑ Anisometropia (3.00 diopters or more, provide Rx)
- ❑ Aphakia
- ❑ Corneal Dystrophy*
- ❑ Corneal Transplant*
- ❑ High Ametropia (+/-10.00 diopters, provide Rx)
- ❑ Keratoconus*
- ❑ Nystagmus
- ❑ Physical condition of ears or nose prohibiting the use of glasses (please describe below.)

*Requires improvement in best corrected visual acuity by two lines compared to spectacles.

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- ❑ Other Corneal Conditions* (please specify diagnosis code(s) below.)

*See VSP Manual for conditions that require improvement in best corrected visual acuity by two lines compared to spectacles.

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Current Spectacle Refraction (Without Contats)

Right:

Sph:______Cyl:______X______Add:______Prism:______

Left:

Sph:______Cyl:______X______Add:______Prism:______

Please fax this form to **916.851.4733** or mail to **VSP, PO Box 495907, Cincinnati, OH 45249-5907**

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

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Classification: Public