## **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 N	lame:						
Provider Number:		Phone Number:		Fax Number:			
Participant Name:				Date of Birth:			
Participan	t Medicaid Nu	mber:		Date of Servic	e:		
Service/	Procedure	Code Requeste	d For Review:				
High Index Lens Procedure Code:			Aspheric Lens Procedure Code:				
Contact Le	ens Procedure	Code:	Quantity (exact nu	mber of contact lense	s per eye x 1 year)		
Specialty Frame Procedure Code:			Tinted Lens Procedure Code:				
Lenticular Lens Procedure Code:			Early Exam Procedure Code:				
Polycarbonate Lens Procedure Code:							
	Current RX B						
D.V.	O.D	Spherical	Cylindrical	Axis	Prism	Base	
	O.S.						
N.V.	O.D						
	O.S.						
Note: If	_	previous RX below a		es RX. If change is co	ontacts to glasses pro	vide old and new	
Indicate	Previous RX	Below					
Rx Date:		Spherical	Cylindrical	Axis	Prism	Base	
D.V.	O.D						
	O.S.						
	O.D						
	O.S.						
		ole: Broken	Lost Out Gro	own Vision C	hange		