IDAHO MEDICAID VISION CONTACT FITTING FEE AUTHORIZATION FORM

Please complete the entire form and submit with all required documentation to (877) 314-8779

Medicaid Participant Information		
Last Name:	First Name:	Initial:
Medicaid ID:	Phone:	DOB:

Medicaid Vision Provider Information	
Provider Name:	Physician's NPI:
Contact Person:	Email:
Phone:	Fax:

Diagnosis That Pertain TO Criteria

☐ Keratoconus
☐ Myopia +/-10.0 diopter
☐ Hyperopia +/-10.0 diopter
☐ Anisometropia
☐ Other (Note Below)

Other Diagnosis:

Participants age 21 and older: Fitting fee for contact lenses will be covered only when necessary to treat a chronic condition, such as keratoconus, that progressively degrades vision. A letter of medical necessity, and notes from the last two visits, are required for all contact lenses prior authorization requests.

Participants under 21 years of age: Fitting fee for contact lenses will be covered for extreme myopia or hyperopia requiring a correction equal to, or greater than, minus or plus ten (10.0) diopters in at least one eye, keratoconus, anisometropia (a 3.0 diopter difference between eyes), or other extreme medical conditions precluding the use of eyeglasses as defined by the Department.

Fitting Fee Requested – Authorization will be made to the provider

Date of Service: ________________

Trial Lens? ☐ Yes ☐ No

Fitting Fee: ☐ 92071 ☐ 92072 ☐ 92310 ☐ 92311 ☐ 92312 ☐ 92314

The status of a prior authorization request may be checked online at the **www.IDMedicaid.com** under "Authorization Status", using your NPI, or by contacting DXC at **(866) 686-4272.**

For questions email the Medical Care Unit at: MedicalCareUnit@dhw.idaho.gov
More information is available at www.MedUnit.DHW.Idaho.gov and clicking on Vision

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