

DETAILED WRITTEN ORDER FOR OCULAR PROSTHETIC SERVICES

TO: Advanced Eye Prosthetics, LLC
3305 W Mayflower Ave Ste 4, Lehi, UT 84048 P: 833-208-9009 F: 866-680-1322

**THIS IS NOT A STANDALONE DOCUMENT
IT MUST BE ACCOMPANIED BY MEDICAL RECORDS TO SUBSTANTIATE MEDICAL NECESSITY
(I.E., CLINICAL NOTES, OPERATIVE REPORT, AND/OR PHYSICIAN RECOMMENDATION)**

PATIENT NAME: _____ **DOB:** _____

PATIENT ID OR CHART # _____

DIAGNOSIS CODE & DESCRIPTION:

PROCEDURE ORDER: ☐ RT, OD ☐ LT, OS ☐ Both, OU

- ☐ V2623 Custom ocular prosthesis (utilized in the enucleated, eviscerated, or anophthalmic eye socket); recommended every 5 years
- ☐ V2624 Polishing of ocular prosthesis (utilized to resurface a prosthesis for dullness, scratches, and/or protein deposits); recommended every 6 months
- ☐ V2625 Enlargement of ocular prosthesis (utilized to refit a prosthesis when normal settling of the socket or globe has occurred requiring enlargement of prosthesis); recommended as needed
- ☐ V2626 Reduction of ocular prosthesis (utilized to refit a prosthesis when normal settling of the socket or globe has occurred requiring reduction of prosthesis); recommended as needed
- ☐ V2627 Custom scleral cover shell prosthesis (utilized in the phthisical or microphthalmic socket or when a partial or complete blind globe requires prosthetic rehabilitation);
- ☐ V2628 Custom ocular conformer (utilized post-operatively to develop socket depth or rehabilitate a microphthalmic and/or contracted socket—conformer therapy— or as a trial shell prior to prosthesis fitting); # of units: _____

LENGTH OF NEED:

Ocular prosthesis: Lifetime

Polishing: Every 6 months

PHYSICIAN SIGNATURE (must be original): _____

DATE: _____ NPI: _____

Printed physician name: _____

Address: _____

Phone: _____ Fax: _____