

PLEASE FAX THIS SIGNED & DATED ORDER TO OUR OFFICE AND MAINTAIN A COPY IN PATIENT'S MEDICAL FILE

## **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: \_\_\_\_\_