



OCULAR PROSTHETICS, LLC

Certificate of Medical Necessity – Ocular Prosthesis Services

Aligned with coverage criteria in CMS LCD L33737. Please return by fax to (864) 305-4369 or email admin@gbprosthetics.com.

SECTION A: Certification Type / Date / Patient Information (completed by supplier/ocularist)

Patient Name: _____

Patient Date of Birth: _____

Medicare (MBI) / Insurance ID: _____

Date of Order: _____

Quantity: _____

Supplier Name: GB Ocular Prosthetics LLC

Supplier Address: 355 Woodruff Rd Suite 405, Greenville SC 29607

Supplier Phone / Fax: (864) 278-1881 / Fax (864) 305-4369

Supplier NPI: 1700602760

SECTION B: Medical Information (completed by the treating physician)

1. Diagnosis / ICD-10 Code(s):

- ☐ Z90.01 – Acquired absence of eye
- ☐ Q11.1 – Anophthalmos
- ☐ Q11.2 – Microphthalmos
- ☐ Z44.20 – Encounter for fitting and adjustment of artificial eye (fitting encounter code)
- ☐ Other ICD-10 (e.g., for scleral shell cases): _____

2. Date of Onset or Surgery: _____ (e.g., date of eye removal or injury)

3. Type of Service Requested (check all that apply):

- ☐ Custom-made artificial eye (HCPCS V2623)
- ☐ Scleral shell (HCPCS V2627)
- ☐ Conformer (HCPCS V2628 – fabrication and fitting of ocular conformer)
- ☐ Adjustment of prosthesis (e.g., enlargement V2625, reduction V2626)
- ☐ Cleaning / polishing / resurfacing of prosthesis (HCPCS V2624)

Expected Duration of Need: ☐ Permanent ☐ Temporary (specify: _____ months/years)

Additional Comments / Supporting Documentation (attach medical records, operative reports, or photos if needed):



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Medical Necessity Justification

Due to absence or significant shrinkage of the eye, this prosthesis is medically necessary to (check all that apply):

- ☐ Restore facial symmetry
- ☐ Maintain socket health
- ☐ Prevent socket contraction
- ☐ Support orbital development

If replacement: Age of last prosthesis: _____

For adjustments/cleaning, functional issues: ☐ Discomfort ☐ Settling of tissue in the socket ☐ Irritation

☐ Poor fit ☐ Matter build-up

☐ I authorize the supplier at GB Ocular Prosthetics to administer topical anesthetic if needed prior to impression of globe or socket.

SECTION C: Physician Attestation and Signature

I certify that the above information is true, accurate, and complete to the best of my knowledge. The patient's medical condition requires the ocular prosthesis services described, and they are reasonable and necessary for the diagnosis or treatment of the illness or injury. I have reviewed the patient's records and confirm the need. This certification is based on my clinical judgment and the patient's current condition.

Physician Name (Printed): _____

Physician NPI: _____

Physician Signature: _____ Date: _____

SECTION D: Supplier Attestation

I certify that I have received this completed CMN and that the services will be provided as ordered.

Supplier Representative Signature: _____ Date: _____

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