## **AVĒSIS VISION AUTHORIZATION FORM**



Please fill out form in its entirety for timely processing and send form to secure fax: 855-591-3566.

## **AUTHORIZATION TYPE**

Urgent	t	Prior Authorization	Re	tro Authorization		
MEMBER						
						Plan ID: Todays Date:
PROVIDER						
First Name: Phone: RENDERING LOCATION			Last Name:			NPI: Fax:
Service Location N				Outpatient Facility No		
City:			State:			Zip:

## PROCEDURE

Date of Service (if not available note TBD):

CPT/HCPCS	DESCRIPTION	UNITS	DIAGNOSIS CODE(S)	DIAGNOSIS DESCRIPTION	MODIFIER

 If requesting additional frame or lens benefits please include a copy of member's current and previous glasses prescriptions along with best corrected visual acuities. • Please link the correct diagnosis code to procedure (CPT) code being submitted. If not, you are subject to a denial due to this.

## PERTINENT CLINICAL SUMMARY (ATTACH SUPPORTING CLINICAL RECORDS):

This document is a determination of a request for authorization to perform services that require prior approval and in no way guarantees or implies that payment will be made. Payment is contingent upon the Member's benefit eligibility on the date the approved services are rendered as well as other factors. Avesis will not consider request for authorization if clinical information is not attached.