EYEMKR, LLC – Custom Prosthetic Eyes

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EYEMKR Custom Prosthetic Eyes Referral Form

Thank you for referring your patient to **EYEMKR CUSTOM PROSTHETIC EYES**. We specialize in custom, hand-crafted prosthetic eyes with an emphasis on comfort, fit, maintenance, and aesthetics. Please complete the form below so we can best support your patient.

Referring Provider Information

Provider Name / NPI:

Practice / Facility Name:

Phone Number:

Fax Number:

Email Address:

Practice Address:

Patient Information

Patient Name: _____ **Date of Birth:** ____ / ____ / _____

Phone Number: ( )_____ **Email Address:**_____

Clinical Information

Affected Side:
☐ Right
☐ Left
☐ Bilateral

Reason for Eye Loss (ICD-10 diagnosis code): _____

Current Status:
☐ First-time prosthetic eye
☐ Existing prosthetic eye
☐ Post-enucleation
☐ Post-evisceration

Date of Surgery (if applicable):
____ / ____ / _____

Implant Type (if known): _____

Referral Reason (check all that apply)

☐ Custom Prosthetic Eye Fabrication
☐ Evaluation
☐ Routine Maintenance/ Adjustment/ Clean and Polish

☐ Other: _____

please attach any relevant medical documents

Insurance Information (if available)

Primary Insurance / Member ID:

Secondary Insurance / Member ID:

Authorization

By submitting this referral, I authorize EYEMKR Custom Prosthetic Eyes to contact the above patient to discuss prosthetic eye services and scheduling.

Referring Provider Signature: _____ Date:____ / ____ / _____

Submission Options **(Email:** sparkle@eyemkr.com **Fax:** (530)285-8553 **Mailing:** 341 Broadway St, Suite 314, Chico, CA 95928)
Thank you for your referral. Please contact us if you have any questions or need help filling out this form.