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 ☐ Prior Authorization ☐ Retro Authorization

MEMBER

First Name: _____ Last Name: _____ Plan ID: _____

Phone: _____ Date Of Birth: _____ Today's Date: _____

PROVIDER

First Name: _____ Last Name: _____ NPID: _____

Phone: _____ Office Contact: _____ Fax: _____

RENDERING LOCATION

Select Type: ☐ Office ☐ Outpatient Facility

Room, Board, and Anesthesia Required? ☐ Yes ☐ No

Service Location Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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):

_____

_____

_____