LOW VISION VERIFICATION

Use this form to request low vision evaluation and aids. Refer to the **Plans and Coverages** section in the VSP® Manual on **VSPOnline** for requirements and limitations.

Doctor NPI ______________________

Doctor Name ______________________

Address ______________________

City, State, Zip ______________________

Phone (________) ______________________

Fax (________) ______________________

Office Staff Contact Name ______________________

Date of Service ______________________

Member ID (or last four of SSN) ______________________

Authorization Number ______________________

Patient Name ______________________

Patient Date of Birth ______________________

Member Name ______________________

Member Date of Birth ______________________

Member Address ______________________

____

REQUEST IS FOR ❑ Low Vision Evaluation – U&C fee for proposed evaluation $______________ ❑ Low Vision Aids

PATIENT'S DIAGNOSES

Indicate the patient's low vision diagnosis.

DIAGNOSIS CODE 1. ______________ 2. ______________ 3. ______________

4. ______________ 5. ______________ 6. ______________

BEST CORRECTED VISUAL ACUITY

RIGHT: Dist ______ /______ Near ______ /______ **LEFT:** Dist ______ /______ Near ______ /______

COMPLETE THIS SECTION FOR LOW VISION AIDS PROPOSED

(Catalog price sheets or invoices required for each aid to support the wholesale cost listed.)

Low Vision Aid	Model #	Mon/ Bin	Visual Acuity	Patient Use of Aid	Wholesale Cost	Doctor's U&C
		M B				
		M B				
		M B				
		M B				
		M B				
		M B				

Please fax this form to **916.851.4733** or mail to VSP, PO Box 385020, Birmingham, AL 35238-5020.

IMPORTANT: Forms received with missing or incomplete information won't be processed.

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