MATERIALS VERIFICATION

Refer to the **Plans and Coverages** section in the **VSP® Manual** on **VSPOnline** for requirements and limitations. If limitations prevent submission through Eyefinity®, use this form to request necessary contact lenses.

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 ____________________

____

NECESSARY CONTACT LENSES (MARK REASON)

- ❏ Aniridia
- ❏ Anisometropia (3.00 diopters or more, provide Rx)
- ❏ Aphakia
- ❏ Corneal Dystrophy
- ❏ Corneal Transplant
- ❏ High Ametropia (+/-10.00 diopters, provide Rx)
- ❏ Keratoconus
- ❏ Nystagmus
- ❏ Physical condition of ears or nose prohibiting the use of glasses (please describe below.)

  ____

  ____

- ❏ Other Corneal Conditions (please specify diagnosis code(s) below.)

  ____

CONTACT LENS POWER

Right: ____________________

Left: ____________________

CURRENT SPECTACLE REFRACTION (WITHOUT CONTACTS)

RIGHT:
Sph: _____ Cyl: _____ X _____ Add: _____ Prism: _____

LEFT:
Sph: _____ Cyl: _____ X _____ Add: _____ Prism: _____

BEST CORRECTED SPECTACLE VISUAL ACUITY

RIGHT:
Dist: _______ /_______ Near: _______ /_______

LEFT:
Dist: _______ /_______ Near: _______ /_______

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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