PROTEC SAFETY®
PLAN VERIFICATION

Today's Date_____

Doctor NPI_____

Doctor Name_____

Address_____

_____

Phone_____

Fax_____

Office Staff Contact Name_____

Member ID No._____

Patient Name_____

Patient Date of Birth_____

Member Name_____

Address_____

Date of Service_____

Authorization No. (must be used when billing claim)

_____

PLEASE INDICATE THE REASON THIS PATIENT CAN'T USE A PROTEC EYEWEAR® FRAME. (CHECK ALL THAT APPLY.)

- ☐ The needed eye size isn't available in any of the covered frames.
- ☐ None of the frames meet the hazardous work environment needs of your patient.
- ☐ The patient has an allergy to the standard safety frame materials used in the covered frames.

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

IMPORTANT: The following information is required. Forms received with missing or incomplete information won't be processed. Please type or print clearly.