EyeMed
4000 Luxottica Place
Cincinnati, OH 45040
Visit us online at www.eyemed.com
Fax claim form to 866.293.7373

Medically Necessary Contact Lens Claim Form

Provider Reimbursement

Patient Information (Required)

Last Name	First Name	Middle Initial

Street Address	City	State	Zip Code

Birth Date (*MM/DD/YYYY*)	Telephone Number (with area code)
- -	- -
Member ID # (*if applicable*)	Relationship to the Subscriber Self ☐ Spouse ☐ Child ☐ Other ☐

Subscriber Information (Required)

Last Name	First Name	Middle Initial

Street Address	City	State	Zip Code

Birth Date (*MM/DD/YYYY*)	Telephone Number (with area code)
- -	- -
Vision Plan Name	Vision Plan/Group #
Date of Service (**Required**) (*MM/DD/YYYY*) - -	Authorization # :

Medically Necessary Codes (Includes Contact Lens Evaluation/Fit and Follow and Materials) - SUBMIT AS PRIMARY

Check ALL CODES that apply to final Rx, as published in the EyeMed Professional Provider Manual

☐ **Anisometropia** **92310AN** Select this if Rx is 3D in meridian powers. Check this box and the box below. Reimburses up to $700 for services and materials.	☐ **High Ametropia** **92310HA** Select this if Rx exceeds -10D or +10D in meridian powers in either eye. Reimburses up to $700 for services and materials.	☐ **Keratoconus** **92072** Select this if diagnosis is Keratoconus. Check this box and the one below. Reimburses up to $1200 for services and materials.	☐ **Vision Improvement** **92310VI** **Keratoconus is absent** Select this for members whose vision can be corrected by two lines on the visual acuity chart. Reimburses up to $2500 for services and materials.
☐ **ICD-9 Code** **367.31**		☐ **ICD-9 Code** **371.60**	
U&C $	**U&C $**	**U&C $**	**U&C $**

Complete Information Below for Members Covered by Pediatric Vision Benefits - CALIFORNIA ONLY

☐ **Pediatric Aniridia** **92310AI** (CA only) Reimburses up to $3730 for services and materials.	☐ **Pediatric Aphakia** **92310AP** (CA only) Reimburses up to $5800 for services and materials.	
☐ **ICD-9 Code** **743.45**	☐ **ICD-9 Code** **379.31**	
U&C $	**U&C $**	

Request for Material Reimbursement (Enter U&C Amount Charged) - SUBMIT AS SECONDARY

☐ **SO500** $	☐ **V2500-V2503** $	☐ **V2520-V2523** $
☐ **V2599** $	☐ **V2510-V2513** $	☐ **V2530-V2531** $

Important Information

We'll periodically review clinical records to make sure you're correctly applying the medically necessary contact lens benefit. We'll be looking to see that the documented prescription supports the qualifying condition submitted. If the record doesn't support this condition, we'll recoup any overpayment by withholding payment on future claim(s) where law permits. As you may know, we can consider any inaccurate submission to be a false claim. Falsifying information or filing false claims can result in disciplinary action up to and including termination from our network. If we believe you've filed a false claim, we might also have to report it to regulatory and law enforcement agencies as appropriate. See **http://www.eyemedinfocus.com/the-basics/online-provider-manual** for our full Quality Assurance process and disciplinary actions.

Do not file the claim for medically necessary contact lenses electronically. Fax claim form to 866.293.7373
Fax a corrected claim to 866.293.7373; mark the submission "**Corrected Med. Nec. Contact Claim**."

Provider Name:	**Tax ID Number:**

Servicing location name and full address:

Provider Signature:	**Date:**