NC DHB Visual Aid Request for Prior Approval

Recipient Information **DMA372-017A V1.1**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary?
1			
2			

Payer Information

6. The payer for this service is: Medicaid: ☐

Provider Information

7. Requesting/Billing Provider #:_____NPI: ☐ Atypical: ☐ 8. Taxonomy: _____
9. Address: _____ 10. Nine Digit Zip Code: _____
Requestor Contact Information
Name:_____ Phone #:_____ Ext:_____ Fax: _____

Services Information

11. Date Seen for VISUAL AIDS: _____ 12. Date of Refraction: _____
13. Is this request for Complete Glasses W/Medicaid Frame? ☐ 14. Exceptional Service: _____

Frame Information

15. Manufacturer: _____ 16. Model: _____ 17. Material: _____
18. Type: _____ 19. Color: _____ 20. Invoice Cost: _____
21. Eye: _____ Bridge: _____ Temple:_____

Lens Information

22. Style: _____ 23. Material: _____ 24. Tint: _____
25. Lens Circumference Right: _____ Left: _____ Slab Off: ☐ Ultraviolet Filter: ☐

Prescription Information

	Sphere	Cylinder	Axis	Prism	Base	Add	Seg Ht	PD Dist	PD Near	Fresnell	Base
R											
L											

Contact Lens Information

26. Manufacturer: _____ 27. Name: _____ 28. Type: _____
29. Reason for Request: _____ 30. Invoice Cost: _____

Additional Information

Special Instructions for Medicaid contractor laboratory

Requesting Provider's Signature:_____ Date:_____ Fax this form to: (855) 710-1964