

EyeMed  
 4000 Luxottica Place  
 Cincinnati, OH 45040  
 Visit us online at [www.eyemed.com](http://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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		

**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

<input type="checkbox"/> <b>Anisometropia 92310AN</b> Select this if Rx is 3D in meridian powers. Check this box and the box below. Reimburses up to \$700 for services and materials.	<input type="checkbox"/> <b>High Ametropia 92310HA</b> Select this if Rx exceeds -10D or +10D in meridian powers in either eye. Reimburses up to \$700 for services and materials.	<input type="checkbox"/> <b>Keratoconus 92072</b> Select this if diagnosis is Keratoconus. Check this box and the one below. Reimburses up to \$1200 for services and materials.	<input type="checkbox"/> <b>Vision Improvement 92310VI</b> <b>Keratoconus is absent</b> 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.
<input type="checkbox"/> ICD-9 Code 367.31		<input type="checkbox"/> 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**

<input type="checkbox"/> <b>Pediatric Aniridia 92310AI</b> (CA only) Reimburses up to \$3730 for services and materials.	<input type="checkbox"/> <b>Pediatric Aphakia 92310AP</b> (CA only) Reimburses up to \$5800 for services and materials.
<input type="checkbox"/> ICD-9 Code 743.45	<input type="checkbox"/> ICD-9 Code 379.31
U&C \$	U&C \$

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

<input type="checkbox"/> SO500 \$	<input type="checkbox"/> V2500-V2503 \$	<input type="checkbox"/> V2520-V2523 \$
<input type="checkbox"/> V2599 \$	<input type="checkbox"/> V2510-V2513 \$	<input type="checkbox"/> 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.eyemedinfo.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: