AVĒSIS VISION
AUTHORIZATION FORM

Please fill out form in its entirety for timely processing and send form to secure fax: 855-591-3566.

AUTHORIZATION TYPE

☐ Urgent ☐ Prior Authorization ☐ Retro Authorization

MEMBER

First Name: ________ Last Name: ________ Plan ID: ________

Phone: ________ Date Of Birth: ________ Todays Date: ________

PROVIDER

First Name: ________ Last Name: ________ NPID: ________

Phone: ________ Office Contact: ________ Fax: ________

RENDERING LOCATION

Select Type: ☐ Office ☐ Outpatient Facility

Room, Board, and Anesthesia Required? ☐ Yes ☐ No

Service Location Name: ________

Address: ________

City: ________ State: ________ Zip: ________

Phone: ________ Fax: ________

PROCEDURE

Date of Service (if not available note TBD): ________

CPT/HCPCS	DESCRIPTION	UNITS	DIAGNOSIS CODE(S)	DIAGNOSIS DESCRIPTION	MODIFIER

- If requesting additional frame or lens benefits please include a copy of member's current and previous glasses prescriptions along with best corrected visual acuities.
- Please link the correct diagnosis code to procedure (CPT) code being submitted. If not, you are subject to a denial due to this.

PERTINENT CLINICAL SUMMARY (ATTACH SUPPORTING CLINICAL RECORDS):

____

____

____

This document is a determination of a request for authorization to perform services that require prior approval and in no way guarantees or implies that payment will be made. Payment is contingent upon the Member's benefit eligibility on the date the approved services are rendered as well as other factors. Avesis will not consider request for authorization if clinical information is not attached.