



OptiCare Managed Vision
112 Zebulon Court

Rocky Mount, NC 27804

Medical Pre-certification Request

Phone Toll Free (800) 465-6972

Please fax your request to: (252) 451-2133

_____ EMERGENT

_____ URGENT

_____ ROUTINE

Date _____ Office Contact _____ Phone _____ Fax _____

Referring Physician _____ Referred to Physician _____ NPI# _____

Co-Management: Please specify Co-managing Provider _____

Patient Name (Last) _____ (First) _____ (Middle) _____ DOB _____

ID # _____ HMO (Plan) _____ Group # _____

Other Insurer (if any) _____

Date of Admit _____ Date of Surgery _____ IP/OP (Circle One) Anticipated LOS _____

Facility Name & Address _____

Diagnosis: (must be provided)

Procedure: (must be provided)

ICD 9 _____ Description _____ CPT _____ Description _____ RT LT 50

ICD 9 _____ Description _____ CPT _____ Description _____ RT LT 50

ICD-9 _____ Description _____ CPT _____ Description _____ RT LT 50

PCP Referral Number: _____ Effective date _____ Expiration date _____

Medical Reason for Request _____

Attach additional pages if necessary

Patient's Subjective Complaint: _____

Patient's BCVA: OD _____ OS _____

Signature of Attending Physician: _____ Date _____

Office Location: _____

PRE CERTIFICATION/AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. COVERED SERVICES ARE BASED ON MEMBER ELIGIBILITY AND BENEFIT LIMITATIONS AT THE TIME SERVICE(S) ARE RENDERED.

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Reviewing Physician _____ Approve _____ Approved LOS _____

Denied: _____ Rationale for Denial: _____

Recommendation for alternative treatment(s) _____

Reviewing Physician Signature _____ Date _____

Authorization # _____ or Denial Reference # _____ Date _____

Medical Claims Administrator Signature _____

If Denied: Please refer to your Provider Manual or call 1-800-465-6972 to be informed of your appeal rights

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