



MEDICAL MANAGEMENT
PRIOR NOTIFICATION FORM

DATE: _____ DATE OF SERVICE _____ PLEASE FAX REQUEST TO 1-252-451-2140

(PLEASE INCLUDE PERSON'S NAME WITH WHOM YOU HAVE SPOKEN)

REPRESENTATIVE SPOKEN TO - _____

MEMBER NAME: _____

MEMBER ID: _____ DOB: _____

HEALTH PLAN: _____

PROCEDURE AND MODIFIER: (Must be provided)

DIAGNOSIS: (Must be provided)

HCPCS/CPT: _____

ICD 9: _____

HCPCS/CPT: _____

ICD 9: _____

REASON FOR REQUEST: _____

NOTE: PATIENT CONVENIENCE OR NON-MEDICALLY NECESSARY ITEMS ARE NOT COVERED.

Presenting Rx: OD: _____ OS _____

New Rx: BCVA (DISTANCE AND NEAR) _____

“Patient must use this benefit within 30 days of approval.”

By signing the form below, the prescribing provider certifies that the item(s) requested is medically necessary and that it conforms to accepted methods of diagnosis and treatment.

PROVIDER NAME (PLEASE PRINT)- _____

PROVIDER SIGNATURE REQUIRED- _____

OFFICE LOCATION: _____

TAX ID # - _____

FAX # - _____

TELEPHONE # - _____

PERSON TO CONTACT WITH DETERMINATION - _____

For Internal Use Only:

Table with 4 columns: Received Date, Approval #, Completion Date, Medical Management Use