# Ohio Medicaid
# Medically Necessary Contact Lens Form

**Instructions:** Complete this form and fax it to 866.293.7373.

Patient/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) | | |
| Member ID # (*if applicable*) | | | |
| Vision Plan Name | Vision Plan/Group # | | |
| Date of Service **(Required)** (*MM/DD/YYYY*) | | | |

The benefit covers fit and follow-up services and an annual supply of lenses.

Check **one** fitting code.

| | | Service | Retail cost |
|---|---|---|---|
| | 92310 | Fitting of contact lenses; corneal lens, both eyes, except for aphakia | |
| | 92311 | Fitting of corneal contact lens for aphakia, one eye | |
| | 92312 | Fitting of corneal contact lens for aphakia, both eyes | |
| | 92071 | Fitting of contact lenses for treatment of ocular surface disease | |
| | 92072 | Fitting of contact lenses for management of keratoconus | |

Enter the appropriate primary diagnosis code for the contact lenses requested

Enter the number of units dispensed of each type of lens for the right and left eye respectively.

*# of units for annual supply*

| **Right** | **Left** | | Lens type | Retail cost |
|---|---|---|---|---|
| | | V2500 | Contact Lens Pmma; Spherical | |
| | | V2501 | Contact Lens Pmma;Toric/Prism | |
| | | V2502 | Contact Lens, PMMA Bifocal | |
| | | V2503 | Contact Lens Pmma, for correction of color deficiency | |
| | | V2510 | Contact Gas Permeable; Spherical | |
| | | V2511 | Contact Toric Prism Ballast; gas perm | |
| | | V2512 | Contact Lens, Gas Permeable, Bifocal | |
| | | V2513 | Contact Lens Extended Wear; gas perm | |
| | | V2520 | Contact Lens; Hydrophilic (1 or box of 6) | |
| | | V2521 | Contact lens; Hydrophilic toric (1 or box of 6) | |
| | | V2522 | Contact Lens, Hydrophilic, Bifocal | |
| | | V2523 | Contact Lens, Hydrophilic, Extended Wear | |
| | | V2530 | Contact Lens; Hybrid | |
| | | V2531 | Contact Lens, Scleral | |

Reimbursed up to 100% of Ohio Medicaid fee for service schedule

**Attestation.** By signing below, I attest that the patient meets the requirements to receive medically necessary contact lenses according to the criteria in the EyeMed Provider Manual (available at www.eyemedinfocus.com), and that the patient is unable to achieve adequate functional vision without contact lenses.

| Provider Name | Tax ID Number |
|---|---|
| Servicing location name and full address | |
| Billing location name and full address | |
| Billing NPI | Rendering NPI |
| Provider Signature | Date |