Georgia Medicaid
Medically Necessary Contact Lens
Form

Instructions: Complete this form and fax it and a copy of the Prior Authorization approval letter 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
	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	
		V2510	Contact Gas Permeable; Spherical	
		V2513	Contact Lens Extended Wear; gas perm	
		V2520	Contact Lens; Hydrophilic (1 or box of 6)	
		V2523	Contact Lens, Hydrophilic, Extended Wear	

Reimbursed up to 100% of Georgia 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