EyeMed VISION CARE®

Medically Necessary Contact Lens Benefit EyeMed Addendum

Provider Relations
P 1-800-521-3605
www.eyemedvisioncare.com

Mail to: PO Box 8503
Mason OH 45040

Form Questions
P 1-888-581-3648

Form Submission
F 1-866-552-9115
medexceptions@eyemedvisioncare.com

This form is an addendum to a medically necessary contact lens benefit claim and required for claim submission.

- EyeMed Vision Care provides coverage for medically necessary contact lenses **only** for conditions listed in the protocol on this addendum.
- Contact lenses fitted for other medically necessary purposes or the narrowing of vision fields due to high minus or plus correction will **not** be covered. This benefit is not expandable for conditions outside the protocol.
- Incomplete and/or illegible forms will be rejected.
- Form to be completed by eye care provider.

Provider Information	
Provider ID	Date
Provider Location ID	Federal Tax ID
First Name	Last Name
Address	
Phone	Fax
E-mail	Office Contact Name

Patient Information		
Primary Subscriber ID	Plan ID	
Primary Subscriber Name		
Patient Name	Patient Birth Date (mm/dd/yyyy)	
Patient Address		
City	State	Zip

Protocol & Eligibility/Date of Service Information		
Date of service (mm/dd/yyyy)		Claim previously submitted? ☐ Yes ☐ No
Fitting ☐ OD ☐ OS ☐ OU		Usual and Customary fees (Exam excluded) $
EyeMed Vision Care medically necessary contact lens protocol. Check the applicable condition(s): ☐ **Anisometropia** of 3D in spherical equivalent or more ☐ **High Ametropia** exceeding –10D or +10D in spherical equivalent in either eye ☐ **Keratoconus** where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses ☐ **Vision Improvement** for patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses		
Current Refraction Rx	OD	BVA 20/
	OS	BVA 20/
Keratometry Readings	OD	Mires:
	OS	Mires:
Contact Lens Acuity	OD 20/	OS 20/
Type of lens to be fit:		

Provider Signature:	**Date:**

- Do not file the claim for medically necessary contact lenses electronically. Fax or email the addendum and claim form.
- Obtain Eligibility Authorization: Fax or email a completed addendum to **1-866-552-9115** indicating the date of service, the servicing provider and their location.
- File Claim: Fax or email a completed addendum and a complete CMS 1500 form to **1-866-293-7373.**
- Corrected claim: Fax or email a corrected CMS 1500 form and a corrected addendum to **1-866-293-7373**; mark the submission "Corrected Claim."

The information submitted on this addendum is used to confirm eligibility for the medically necessary contact lens claim. Submission of inaccurate information on this addendum may be construed as filing a false claim. Providers knowingly making, using or causing a false claim to be made or submitting a false record or statement to get a false or fraudulent claim paid will be subject to disciplinary action up to and including the termination of their participation as an EyeMed network provider.