envolve
VISION BENEFITS | Puerto Rico

UTILIZATION MANAGEMENT PRIOR NOTIFICATION REQUEST
PLEASE FAX TO (877) 865-1077

DATE OF REQUEST: _____ CURRENT DATE OF SERVICE: _____

REPRESENTATIVE SPOKEN TO - _____

MEMBER NAME: **_____**

MEMBER ID: **_____** ***DOB:*** **_____**

HEALTH PLAN: **_____** ***OPTICAL LAB:*** **_____**

PROCEDURE AND MODIFIER: (Must be provided) ***DIAGNOSIS: (Must be provided)***

CPT/HCPCS: _____ Modifier: _____ ICD:_____

CPT/HCPCS: _____ Modifier: _____ ICD:_____

CPT/HCPCS: _____ Modifier: _____ ICD:_____

MEDICAL REASON FOR REQUEST: **_____**

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

Presenting Rx:_____OD_____OS _____ADD

New Rx: _____ OD _____ OS _____ADD

Patient must use this benefit within 30 days of approval.

Submission of this form indicates 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 NPI NUMBER -_____

OFFICE ADDRESS: **_____**

TAX ID # - _____

FAX # - _____

TELEPHONE # - _____

PERSON TO CONTACT WITH DETERMINATION – _____

For Internal Use Only:

Received Date	Approval #	Completion Date	Utilization Mgmt. Use

Operations Center
P.O. Box 7548▪Rocky Mount, North Carolina 27804▪Tel: 800-334-3937
Utilization Management: 800-465-6972 ▪ Fax: 877-865-1077