envolve
Benefit Options

superior healthplan

SUPERIOR HEALTH PLAN MEDICAID/FOSTER CARE/CHIP
INSTRUCTIONS FOR OBTAINING PRE-AUTHORIZATION FOR OPHTHALMOLOGY SERVICES

Envolve Vision of Texas, Inc. (Envolve Vision) requires all services listed below be authorized prior to the services being rendered. Request should be submitted no less than five (5) business days prior to the services being rendered. All services are subject to eligibility at the time services are rendered and benefit limitations or exclusions.

Fax the completed form and any supporting clinical information to Envolve Vision at (877) 865-1077. Requests for prior authorizations for blepharoplasty procedures must include original photographs. Digital photographs may be submitted via secure email to visionumauthorization@envolvehealth.com or printed copies may be mailed to the address below. If you do not have access to a secure e-mail program, contact the Utilization Management Department at 800-465-6972 and a Care Manager will send you a secure e-mail. Open the secure e-mail attachment, select "Reply to All", and attach the pre-authorization documents for submission to Envolve Vision.

Envolve Vision of Texas, Inc.
PO Box 7548
Rocky Mount, NC, 27804

Requests from a non-participating provider or services scheduled to be performed in an out of network facility requires prior authorization. The notification process above should be followed.

CODE LIST	DESCRIPTION
11440	EXC BEN LES FCE ERES EYELD NSE; 0.5/<
11441	EXC BEN LES FCE ERS EYELD; 0.6-1.0
11442	EXC BEN LES FCE ERS EYELD; 1.1-2.0
11443	EXC BEN LES FCE ERS EYELD; 2.1-3.0
11444	EXC BEN LES FCE ERS EYELD; 31.-4.0
11446	EXC BEN LES FCE ERS EYELD; >4.0
15820	BLEPHAROPLASTY LOW ER EYELID
15821	BLEPHAROPLASTY LOW ; W/EXTEN HERNIAT FAT PAD
15822	BLEPHAROPLASTY UPPER EYELID
15823	BLEPHAROPLASTY UPPER; W /EXCESS SKIN WT DOWN LID
21280	MEDIAL CANTHOPEXY (SEPART PROC)
21282	LAT CANTHOPEXY
67715	CANTHOTOMY (SEPART PROC)
67900	REPR BROW PTOSIS
67901	REPR BLEPHAROPTOSIS; W /SUTUE/OTHER MAT
67902	REPR BLEPHAROPTOSIS; W /FASCIAL SLING
67903	REPR BLEPHAROPTOSIS; LEVATOR RESECT-INT APPROACH
67904	REPR BLEPHAROPTOSIS; LEVATOR RESECT-EXT APPROACH
67906	REPR BLEPHAROPTOSIS; SUPER RECTUS TECH-FASCIAL
67908	REPR BLEPHAROPTOSIS; CONJUNC-TARSO-MULLER'S
67909	REDUCTION OVERCORRECTION PTOSIS
67911	CORRECT LID RETRACTION
67914	REPR ECTROPION; SUTURE
67915	REPR ECTROPION; THERMOCAUTERIZATION
67916	REPAIR ECTROPION EXC TARSAL W EDGE
67917	REPAIR OF ECTROPION EXTENSIVE
67921	REPR ENTROPION; SUTURE
67922	REPR ENTROPION; THERMOCAUTERIZATION
67923	REPAIR ENTROPION EXC TARSAL W EDGE
67924	REPAIR OF ENTROPION EXTENSIVE
67950	CANTHOPLASTY
67961	EXC & REPR EYELID; UP TO 1/4 LID MAR
67966	EXC & REPR EYELID > 1/4 LID MARGIN
67971	RECON EYELID FULL THICK; UP TO 2/3 L
67973	RECON EYELID; TOT LID LOW ER 1 STAGE/
67974	RECON EYELID; TOT LID UPPER 1 STAGE/
67975	RECON EYELID FULL THICK-TRANSF FLAP
J2778	LUCENTIS
J0178	EYLEA
J2503	MACUGEN
J3396	VISUDYNE

REQUEST FOR PRIOR AUTHORIZATION

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Date of Request* ☐☐ / ☐☐ / ☐☐☐☐

*Required items. Please write only in designated areas.

Member Information

Member ID*

Date of Birth* ☐☐ / ☐☐ / ☐☐☐☐

Last Name

First Name

Provider to Perform the Service

NPI*

TPI*

Tax ID*

Last Name, First Name

Fax Number*

Contact Number*

Contact Name / Requestor

Medicaid #______________________ Medicare # ______________________

Facility Information

☐ 'X' in box if office procedure

NPI*

Tax ID*

Facility Name

Fax Number*

Contact Number*

Contact Name / Requestor

Requested Service

Type of Service

☐ DME Rental* ☐ DME Purchase* ☐ DME Incontinence Supply*

☐ Home Health ☐ SNV ☐ PDN ☐ Therapy

☐ Genetic Testing Type:__________ Pregnant ☐ Yes ☐ No

☐ Outpatient Services ☐ Office Visit

☐ Rehab ☐ Evaluations ☐ Re-Evaluations

☐ Inpatient

☐ Other ________________

LTSS Services

☐ PAS

☐ DAHS

☐ ERS

☐ Home Delivered Meals

☐ Med Box Refills

☐ Other ______________

Place of Service*

☐ Office

☐ Outpatient Hospital / ASC Gen

☐ Home

☐ Outpatient Clinic

☐ Outpatient Rehab

☐ Inpatient

☐ Other____________

*All DME require signed physician orders. All HH and Rehab requests require signed physician's order and plan of care/treatment plan.

Clinical Review

Procedure Codes

Procedure code / CPT, HCPCS* modifier

Procedure code / CPT, HCPCS* modifier

Procedure code / CPT, HCPCS* modifier

Diagnoses

Diagnosis Code*

Diagnosis Code

☐ 'X' indicates clinicals or plan of care

Chief Complaint / Service Description

☐☐ / ☐☐ / ☐☐☐☐ Start date*

☐☐ / ☐☐ / ☐☐☐☐ End date*

Units / Visits* ☐ Day ☐ Week ☐ Month

Contact Information

Fax Number:
1-877-865-1077

☐ Urgent Request - By checking this box, I certify that this is an urgent request medically necessary treatment, which must be treated within 24 hours.

____
Signature of Requesting Physician *(required)*

Envolve Vision requires services be approved before the service is rendered. Please refer to the Envolve Vision website, https://visionbenefits.envolvehealth.com/logon.aspx for the most current full listing of procedures and services that require prior authorization. An authorization is not a guarantee of payment and is subject to utilization management review, benefits and eligibility.

For Office Use Only

Authorization Number: Units: _____
Dates Authorization: _____