INLAND EMPIRE HEALTH PLAN

MAIL TO: P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

FAX TO: (888) 860-1299

VISION EXCEPTION REQUEST (VER) FORM

Date of Request:_____

Member Name:_____ Member ID#:_____ DOB:_____

Member Address: _____ City: _____ Zip:_____ Phone: (____)_____

Provider Name:_____ Provider ID#: 9V_____

Please Check All That Apply

REQUEST FOR PROFESSIONAL SERVICES

Examination (within 24 months of last benefit) ☐ 92012 Intermediate – Estab ☐ 92310 Contact Lens Evaluation
☐ 92002 Intermediate – New ☐ Other CPT:_____

Reason:_____

REQUEST FOR MATERIALS

Replacement of Materials (within 24 months of previous benefit): ☐ Frame
☐ Single Vision ☐ Bifocal

Reason: ☐ Broken/Damaged Frames ☐ Replacement of Lost Glasses
☐ Broken/Damaged Lenses ☐ Replacement of Stolen Glasses
☐ Change in Prescription (Meets minimum criteria as listed on Page III.C.3 of IEHP Vision Provider Handbook)

** **Both** items below must be satisfied and checked to qualify for approval of Replacement Frames and/or Lenses:*

☐ Member has supplied the Provider with a signed statement under penalty of perjury that describes the circumstances of the loss or destruction, the steps taken to recover the lost item and that the loss, breakage or damage was beyond the Member's control.

☐ Provider certifies that specific items require replacement and no obvious fraud or intentional abuse is evident.

Request for Polycarbonate Lenses: ☐ Single Vision ☐ Bifocal

☐ Prescription greater than or equal to -6.00 or +5.00 in any meridian?
☐ Monocular Status (One eye BCVA worse than 20/70)
☐ Other _____

_____

** Polycarbonate lenses require prior VER approval and must be fabricated by an IEHP Contract Optical Lab.*

FOR MEDICALLY NECESSARY CONTACT LENSES ONLY

☐ Bilateral ☐ Right Only ☐ Left Only **Contact Lenses Type:** ☐ RGP Sphere ☐ RGP Toric ☐ Soft Sphere ☐ Soft Toric ☐ Other

Proposed CL Specifications: Right: Base Curve: _____ Diameter: _____ Power: _____ Type/Mfg: _____
Left: Base Curve: _____ Diameter: _____ Power: _____ Type/Mfg: _____

Keratometry Reading:
Right: _____ D/_____ D x_____
Left: _____ D/_____ D x_____

Grade of Mire Distortion:
0 +1 +2 +3 +4
0 +1 +2 +3 +4

BCVA with Diagnostic CLs (if available)
Distance_____/_____ Near ____/_____
Distance_____/_____ Near ____/_____

Diagnosis & Medical Justification: _____

I certify, under penalty of perjury, that the information contained herein is true, current, correct and complete to the best of my knowledge. I understand all claims are subject to retrospective review. I verify that the above specifications meet minimum Medi-Cal prescription requirements.

_____ _____
Provider Signature *Date*

FOR IEHP USE ONLY ☐ **Denied** ☐ **Approved** ☐ **Approved/Modified** ☐ **Need More Information**
Comments: