Multi-Specialty Services
CONTACT LENS INFORMATION FORM

Return to:
eQHealth Solutions
Attn: Multi-Specialty Services
Fax:855-440-3747

I. GENERAL INFORMATION		
Recipient ID#:	Last Name:	First Name:
Provider:	Date of Service:	Spectacle Prescription: OD___________ __ OS___________

II. REQUEST INFORMATION: Please check ONE appropriate response for each number item

1. Is this a request for a	New fitting	Refit fitting	Replacement lens(es)
2. Is this contact request for	One eye	Two eyes (i.e. unilateral or bilateral)	
3. Is this request for	Spherical contact lens	Toric/Prism type contact lens	
4. Is the contact lens material	PMMA	Rigid gas permeable	Hydrophilic
5. Is this contact lens(es) to be used for	Daily wear	Extended wear	
6. Is this contact lens request for	Aphakia	Not for aphakia	
7. Is this a special fitting (i.e., Keratoconus, Corneal transplant, trauma, nystagmus, anisometropia, or other)	Yes	No	

IF YES: Please provide diagnostic data, bilateral Rx, signs and symptoms and any other data relevant to this case:

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III. PRICING INFORMATION (excluding examination): Please refer to the current Visual Services Handbook and Visual Services Fee Schedule to ensure the appropriate procedure codes are being used for this request.

Procedure Code	Quantity	Total Fee (in dollars)
______________________	__________	$______________________
______________________	__________	$______________________
______________________	__________	$______________________

This form must be completed and submitted with a completed eQHealth Multi-Specialty Services Authorization Request Form to eQHealth Solutions. A determination for payment cannot be made without the information requested on both forms.