Medical Prior Approval Form – Medical and Ancillary Services

Patient Information

Member Identification Number	Patient Birth Date / /	Age	Auth # (if provided)
Patient Name (Last, First, Middle)			Sex (M/F)

Provider Information

Provider Number - NPI	Provider Name	
eyeQuest User Number	Office Name	
Street Address		Telephone Number ( )
City/State		Zip Code

Requested Services (please list all applicable CPT and ICD codes):

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Reason for additional service(s) – (Provide Brief Description and attach any relevant records and/or test results that will aid in the consideration of this request):

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Prescription (If Pertinent)

		SPHERICAL	CYLINDRICAL	AXIS	PRISM
Distance	**O.D.**				
	O.S.				
Add	**O.D.**		Additional Information		
	O.S.				

Best Visual Acuity (BVA)

		Acuity
Distance	O.D.	
	O.S.	
Near	O.D.	
	O.S.	

____ ______________________

Signature of Provider Date

PLEASE SEND SIGNED FORM TO EYEQUEST AT:
Fax: 888-696-9552
Email: EyeQuest@dentaquest.com
Mailing address: 11100 W. Liberty Drive. Milwaukee, WI 53224