



MEDICAL ASSISTANCE DIVISION
 PO Box 2348
 Santa Fe, New Mexico 87504-2348

**EYE SERVICES
 PRIOR APPROVAL REQUEST
 ♦ CONTACT LENSES ♦**

Patient Name	ID Number	Sex	Birth Date
		M F	
Patient Address – No. & Street/PO Box/R. Rt			
City	State	Zip Code	

Provider

Ordering Physician's Name, Address, Zip Code

USE SNELLEN NOTATION

PRIOR Rx Date		VA with Old Rx	VA No Rx	NEW Rx Date		Corrected VA
Distance	R			Distance	R	
	L				L	
Near Or add	R			Near Or add	R	
	L				L	

COMMENTS/JUSTIFICATIONS

Pair of Contact Lenses	Diagnosis of keratoconus of ± 3.00 of anisometropia or a correction of ± 6.00 diopters	
Single Contact Lens	Monocular aphakia	
DATE of EXAM	TYPED or PRINTED Provider Name	Signature of Provider
MO. Dy. Yr.		

RECOMMENDATIONS

Date	Reviewer
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