

**MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 PREAUTHORIZATION REQUEST FORM
 VISION CARE SERVICES**

SECTION I - Patient Information

Medicaid Number											
Name											
	(Last)	(First)	(MI)	DOB	Sex	Telephone ()					
Address											

SECTION II - Preauthorization General Information

Pay to Provider Number								
Name							Date Service Requested by	
Address							Provider	
Contact							Telephone ()	
Provider's Signature								

SECTION III - Additional Preauthorization Information

Give Reason(s) for Requested Service

SECTION IV - Preauthorization Line Item Information

DESCRIPTION OF SERVICE	PROCEDURE CODE	REQUESTED		AUTHORIZED	
		UNITS	AMOUNT	UNITS	AMOUNT
			\$		\$
			\$		\$
			\$		\$
			\$		\$
			\$		\$

PREAUTHORIZATION NUMBER

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DOCUMENT CONTROL NUMBER
(STAMP HERE)

SUBMIT TO: Program Systems and Operations Administration
 Division of Claims Processing
 P.O. Box 1705B
 Baltimore, Maryland 21201

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SECTION V - Specific Program Preauthorization Information

New Prescription: O.D. _____	Best Visual Acuity _____
O.S. _____	Best Visual Acuity _____
CONTACT LENS REQUESTS:	
Health Condition of each eye:	O.D. _____ O.S. _____
Date of Surgery:	O.D. _____ O.S. _____
Best visual acuity with contact lenses:	O.D. _____ O.S. _____
Advantage of contact lenses over glasses: _____	

SECTION VI (DHCP Only)

_____ APPROVED	_____ DENIED	_____ RETURNED
REASON(s) _____		
MEDICAL CONSULTANT'S SIGNATURE: _____		DATE _____

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
VISION CARE SERVICES

SECTION V - Specific Program Preauthorization Information

New Prescription: O.D.	_____	Best Visual Acuity	_____
	O.S.	_____	Best Visual Acuity _____
CONTACT LENS REQUESTS:			
Health Condition of each eye:	O.D.	_____	O.S. _____
Date of Surgery:	O.D.	_____	O.S. _____
Best visual acuity with contact lenses:	O.D.	_____	O.S. _____
Advantage of contact lenses over glasses:	_____		

SECTION VI (DCMH Only)

_____	APPROVED	_____	DENIED	_____	RETURNED
REASON(s) _____					
MEDICAL CONSULTANT'S SIGNATURE: _____				DATE _____	