Washington State Health Care Authority

Vision Care Authorization Request

PROVIDER INFORMATION	
PROVIDER NAME	PROVIDER NPI
TELEPHONE NUMBER	FAX NUMBER
CLIENT INFORMATION	
CLIENT NAME	PROVIDERONE CLIENT ID
SERVICE REQUEST INFORMATION	
PROCEDURE CODE	DATE
Description of service/item being requested:	
IF CONTACT LENS: Type and Quantity:	Length of time:
What program criteria require you to submit this request?	

MEDICAL INFORMATION		
Related ocular or medical diagnosis:	Dx	ICD
	Dx	ICD
What is the medical justification for this request?		
How will approval of this request functionally benefit the client?		
Is there a less costly alternative? What is it? Why won't it work for this client?		

Attached the following to this request:

- Date of last dispense of glasses and/or contacts
- Copy of prescription
- Copy of previous prescription
- Typed and completed General Authorization for Information form (HCA 13-835)

Fax: 1-866-668-1214 or
Or mail: Medical Request Coordinator
PO Box 45535
Olympia WA 98504-5535