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

SECTION I - Patient Information

Medicaid Number |_|_|_|_|_|_|_|_|_|_|_|

Name _____ DOB _____ Sex ___ Telephone (___) _____
(Last) (First) (MI)

Address _____

SECTION II - Preauthorization General Information

Pay to Provider Number |_|_|_|_|_|_|_|_|_|

Name _____ Date Service Requested by Provider _____

Address _____

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 UNITS	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT
			$		$
			$		$
			$		$
			$		$
			$		$

PREAUTHORIZATION NUMBER

|_|_|_|_|_|_|_|_|_|_|

DOCUMENT CONTROL NUMBER
(STAMP HERE)

SUBMIT TO: Program Systems and Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

SEE REVERSE SIDE

DMH 4Ex6 Rev. 3/97

PA-1

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 (DMMH Only)

_____ APPROVED _____ DENIED _____ RETURNED

REASON(s) _____

MEDICAL CONSULTANT'S SIGNATURE: _____ DATE _____

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SECTION VI (DHMH Only)

_____ APPROVED _____ DENIED _____ RETURNED

REASON(s) _____

MEDICAL CONSULTANT'S SIGNATURE: _____ DATE _____