

**Request for Approval of
Cataract Extraction with Intraocular Lens Implantation**

Member's name: _____

BlueMedicare ID# J _____ DOB: _____

CPT code _____ Surgical site: Right Left Surgery date: _____

Facility name: _____ Facility provider number: _____

Physician name: _____ Physician provider number: _____

Visual complaints: _____

Best-corrected visual acuity, based on a *recent manifest refraction*:

	SPH	CYL	X	AXIS	ACUITY
Right	_____	_____	X	_____	_____
Left	_____	_____	X	_____	_____

If acuity is better than 20/50, include glare test results (low or medium setting): _____

Type of cataract: Nuclear Cortical PSC ASC Clefts / Vacuoles

List any other ocular conditions:

Any effect on visual acuity?
(if yes, please attach clinical documentation)

Yes No

Yes No

Is surgery expected to improve vision? Yes No

Is cataract removal needed for visualization of the fundus? Yes No

If yes, why? _____

Any lens-induced glaucoma or inflammation present? Yes No

Has the patient had cataract surgery in the fellow eye? Yes No Date: _____

Please submit request to:

Blue Medicare HMO / PPO

Fax: (336) 794-1556

Telephone: 1-888-296-9790

Sender's name: _____

Sender's phone #: _____

Origination date: 10/1/06 Revision: Approved by PARTNERS Healthcare Services Medical Management 12/07/2006, 08/02/2007, 07/07/2009