REQUEST FOR SERVICE AUTHORIZATION FOR VISION SERVICES

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 292 (7-2018)

Clear Fields

SEND FORM TO:
Medicaid Prior Authorization
ND Dept of Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0250

FAX: 701-328-1544

I. Recipient Information

Recipient Name		Medicaid ID Number	Date of Birth	
Street Address	City		State	ZIP Code

II. Service Requested

Appointment Date		Exam Code	Refraction Code	Frame Code
Other Procedure Code	Other Procedure Code	Lens Code		Lens Code
Other Procedure Code	Other Procedure Code	☐ OD ☐ OS ☐ OU		☐ OD ☐ OS ☐ OU

ICD Code	ICD Code	ICD Code	ICD Code	ICD Code	ICD Code	ICD Code

Explain Medical Necessity (required):

Date of Previous Eye Exam	Date of Previous Lens	Date of Previous Frame

Present Rx:

	Sph	Cyl	x	Axis	Add	VA / HOTV	Prism
OD			x				
OS			x				

New Rx:

	Sph	Cyl	x	Axis	Add	VA / HOTV	Prism
OD			x				
OS			x				

III. Billing Provider Information

Billing Provider Name	NPI	Billing Provider Number	Telephone Number	FAX Number
Billing Provider Street Address	City		State	ZIP Code
Provider Contact Name			Today's Date	

STATE USE ONLY

Exam/Refraction: ☐ Approve ☐ Deny	Frame: ☐ Approve ☐ Deny	Lens(es): ☐ Approve ☐ Deny	Other Prodecure: ☐ Approve ☐ Deny
Comments			
Signature of Reviewer			Authorization Number