

**REQUEST FOR DIAGNOSTIC TESTING FOR PATIENTS AT RISK
FOR GLAUCOMA / OCULAR HYPERTENSION / GLAUCOMA**

Foundation Authorization Request Form

Fax completed form to 707-442-2047 or mail to the Foundation, P.O. Box 1395, Eureka, CA 95502

Incomplete request forms will be returned without being processed. A copy of this form should be kept in the patient's chart.

Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

Foundation Authorization Tracking #: _____	
MEMBER INFORMATION	
Patient Name: _____ Gender: <u>M</u> / <u>F</u> Date of Birth: _____	
Patient's Address: _____	
Street	City
Zip	Phone
Health Plan: Anthem Blue Cross HMO/POS - Blue Shield HMO - Blue Lake Rancheria - Open Door - SJHS Humboldt - Trinidad Rancheria	
Subscriber Name: _____	Group #: _____
Member's Primary Care Provider: _____	Subscriber #: _____
REQUESTING PROVIDER INFORMATION	PROPOSED PROVIDER & FACILITY INFORMATION
Name: _____	Name: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Contact Name: _____	Tax ID # (Out of Area Providers only): _____
Today's Date: _____	Place of Service: _____
Type of Request (circle): <u>Routine</u>	Retroactive Date of Service: _____
Diagnosis: <input type="checkbox"/> Glaucoma Suspect ICD9: 365.00	<input type="checkbox"/> Ocular hypertension ICD9: 365.04
Select one <input type="checkbox"/> Glaucoma ICD9: _____	<input type="checkbox"/> Description: _____ ICD9: _____
Requested Service : Description: _____ CPT: _____ Quantity _____	
Note: CPT 92250 OR 92135 not both	Description: _____ CPT: _____ Quantity _____
	Description: _____ CPT: _____ Quantity _____
	Description: _____ CPT: _____ Quantity _____
	Description: _____ CPT: _____ Quantity _____
In order to process this request the following medical necessity information must also be provided:	
Initial exam: Yes No -> -> Last/previous exam date: _____	
Corrected IOP: _____ OD _____ OS	Optic Disc Description (such as thinning, hemorrhages, etc.):
Abnormal nerve fiber layer thickness: <input type="checkbox"/> No <input type="checkbox"/> Yes	C/D ratios:
Central corneal thinning present: <input type="checkbox"/> No <input type="checkbox"/> Yes	Other pertinent risk factors / symptoms / findings etc.:
Visual field abnormality consistent with glaucoma not otherwise explained: <input type="checkbox"/> No <input type="checkbox"/> Yes	
<ul style="list-style-type: none"> • Approved authorizations are effective from the date they are received and expire three (3) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed. Providers must verify member eligibility within 5 days of the date of service to ensure coverage.. • Claims for services rendered without required prior authorization may be denied reimbursement. Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services. <ul style="list-style-type: none"> • The requesting physician or the member may submit authorization appeals to the Foundation Medical Management Department. • This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety Code §1370, and California Evidence Code §1157. 	
IMPORTANT WARNING	
This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED . If you have received this message by error, please notify us immediately and destroy the related message. You, the recipient are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.	