PREMIER EYE CARE

UNIQUE INSIGHT. BETTER SOLUTIONS.™

MEDICAL OFFICE VISIT AUTHORIZATION REQUEST FORM

Ultimate Health Plans

Fax to Premier Eye Care @ 1-800-523-3788

TODAY'S DATE: _____

MEMBER ID#: _____

MEMBER NAME: _____

MEMBER DOB: _____

REFERRING PCP NAME: _____

SPECIALIST REFERRED TO: _____

REASON FOR THE VISIT: _____

LAST EYE EXAM ON: _____ **BY:** _____

NUMBER OF VISITS REQUESTED: 1 Office Visit

Please complete the following if known:

APPOINTMENT DATE: _____

EYE PROVIDER SCHEDULED TO SEE: _____

DIAGNOSIS / ICD-10: _____

CPT CODES: _____

A copy of the Premier Authorization should be faxed to:

Fax # _____

Attention: _____
(PCP or Office Contact Person Name)