



**Medical Exception Request Form**

**Submit Completed Form and proof of care for qualifying medical condition to:**

**Fax** 1-866-552-9115

**Email:** [medexceptions@eyemedvisioncare.com](mailto:medexceptions@eyemedvisioncare.com)

**Mail to:**

P.O. Box 8504  
Mason, OH 45040

**Provider Form Questions:**

Phone: 1-888-581-3648  
[www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)

- This is for the **New York State Vision Plan**
- To qualify for medical exception:
  1. At least one year must have elapsed since the last date of service; **AND**
  2. Patient must be under the care of a physician for the qualifying medical condition and provide proof of care for the qualifying medical condition at the eye examination; **AND**
  3. Patient must experience significant vision loss due to a qualifying medical condition.  
**Definition of significant prescription change and qualifying medical conditions are listed below.**
- All information must be complete in order for the request to be considered for approval

Provider Information	
Provider ID	Date
Federal Tax ID	Provider Location ID
First Name	Last Name
Phone (xxx-xxx-xxxx)	Fax (xxx-xxx-xxxx)
Patient Information	
Enrollee / Subscriber ID or SSN	Plan ID
Enrollee/ Subscriber Name	
Patient Name	Patient Birth Date (mm/dd/yyyy)
<b>*Enrollee Union or Group:</b> <input type="checkbox"/> BL2 (PEF) <input type="checkbox"/> BL3 (M/C) <input type="checkbox"/> BL4 (PIA) <input type="checkbox"/> BL5 (PBA-T) <input type="checkbox"/> BL6 (PBA-S) <input type="checkbox"/> BL15 (Retiree) * The <u>annual examination</u> will be covered for eligible employees and dependents with a medical condition that may impact their vision refraction and who are referred by a qualified medical provider caring for that condition, regardless of whether the medical condition has caused a vision loss that requires a new prescription.	<b>**Enrollee Union or Group:</b> <input type="checkbox"/> BL8 (ALESU – arbitration eligible) <input type="checkbox"/> BL9 (ALESU – contract affected) <input type="checkbox"/> BL10 (NYSCOPBA – arbitration eligible) <input type="checkbox"/> BL12 (NYSCOPBA– contract affected) <input type="checkbox"/> BL 13 (Council 82 – arbitration eligible) <input type="checkbox"/> BL 14 (Council 82– contract affected) ** If the medical exception is denied, patient is responsible for cost associated with exam and materials
Requested Services/Materials	
<i>All information must be completed for the request to be considered for approval</i>	
ICD-9 Diagnosis Code(s):	
<i>(Definition of significant prescription change requirement: .75D sphere and/or 1.00D cylinder)</i>	
Current Prescription	
OD	BVA 20/
OS	BVA 20/
New Prescription	
OD	BVA 20/
OS	BVA 20/
Qualifying Conditions (Check all that apply):	
<input type="checkbox"/> Diabetes <input type="checkbox"/> Keratoconus <input type="checkbox"/> Cataracts <input type="checkbox"/> Cataract surgery within two years of last prescription <input type="checkbox"/> Prescription Medication (type: _____) <input type="checkbox"/> Other as determined by the Provider Manual	

Services And Materials Requested
<input type="checkbox"/> Contact Lens <input type="checkbox"/> Exam <input type="checkbox"/> Fit and Follow up <input type="checkbox"/> Frame <input type="checkbox"/> Lens <input type="checkbox"/> Occupational Vision Glasses (Must meet criteria. Covered benefit for some groups) <input type="checkbox"/> Standard Polycarbonate Lenses are covered benefit for some groups or in full for monocular adults or adults requiring correction + or -6.00D (If lens, type: _____) <b>** Please note member must purchase materials within 90 days of exam. **</b>

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**\*\*Provider must notify member of approval or denial by close of business following day**