

EXCEPTION REQUEST FOR COVERAGE OF PHAKIC IMPLANTS



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1 Patient's name, initials, or medical record number: _____

2 Age: _____

3 Gender: Male Female

4 Preoperative refraction: OD: _____ OS: _____

5 Uncorrected visual acuity: OD: _____ OS: _____

6 Best corrected visual acuity: OD: _____ OS: _____

7 Anterior chamber depth: OD: _____ OS: _____

8 Degree of cataracts: OD: _____ OS: _____

9 Patient's visual complaints: _____

10 Other options discussed: Reason(s) declined: _____

LASIK _____

PRK _____

RLE _____

Monovision _____

11 Other factors supporting rationale for phakic implants: _____

12 Phakic lens to be used (if exception approved): Staar Visian ICL Ophtec/AMO Verisyse

Insured's Signature (Please do not use signature stamp.)

Date

Insured's Name (Please type or print.)