EXCEPTION REQUEST FOR COVERAGE OF REFRACTIVE LENS EXCHANGE

OPHTHALMIC MUTUAL INSURANCE COMPANY
(A Risk Retention Group)

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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. Axial length: OD: ______________ OS: ______________
8. Degree of cataracts: OD: ______________ OS: ______________
9. Patient's visual complaints: ______________________

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10. Other options discussed: Reason(s) declined:
    - ☐ LASIK ______________________
    - ☐ PRK ______________________
    - ☐ CK ______________________
    - ☐ Monovision ______________________
11. Other factors supporting rationale for refractive lens exchange: ______________________

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______________________________ ______________________
Insured's Signature (Please do not use signature stamp.) *Date*

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Insured's Name (Please type or print.)