

EXCEPTION REQUEST FOR COVERAGE OF REFRACTIVE LENS EXCHANGE



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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 Is PVD present? [] Yes [] No

8 Axial length: OD: _____ OS: _____

9 Degree of cataracts: OD: _____ OS: _____

10 Patient's visual complaints: _____

11 Other options discussed: Reason(s) declined:
[] LASIK
[] PRK
[] CK
[] Monovision

12 Other factors supporting rationale for refractive lens exchange: _____

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

Date

Insured's Name (Please type or print.)