

**OMIC**  
**OPHTHALMIC MUTUAL INSURANCE COMPANY**  
*(A Risk Retention Group)*

**EXCEPTION REQUEST FOR COVERAGE OF  
REFRACTIVE LENS EXCHANGE**

1. Patient name, initials, or medical record number: \_\_\_\_\_
2. Age: \_\_\_\_\_
3. Gender:  Male  Female
4. Pre-operative 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: \_\_\_\_\_
- \_\_\_\_\_

10. Other options:

Options discussed

Reason(s) declined

LASIK

\_\_\_\_\_

PRK

\_\_\_\_\_

CK

\_\_\_\_\_

Monovision

\_\_\_\_\_

11. Other factors supporting rationale for refractive lens exchange: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Insured's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date