HEALTH BENEFITS PROGRAM
Vision Care Prior Approval Form – Eye Wear

Toll Free Line: 1-800-317-7878
Toll Free Fax: 1-888-299-9222

PROVIDER INFORMATION:	PROVIDER NUMBER: ____________________ TELEPHONE NUMBER: ____________________ FAX NUMBER: ____________________

CLIENT INFORMATION: (MUST BE COMPLETED – INCOMPLETE FORMS WILL BE RETURNED)

NAME OF CLIENT: ____

ADDRESS: ____

10 DIGIT STATUS NUMBER: ______________________ DOB:__________________

PERSONAL HEALTH CARE NUMBER (PHN): ______________________________

DOES THE CLIENT HAVE ALTERNATIVE COVERAGE:______________________________

Name of Prescriber: (Optometrist/Ophthalmologist) **COPY OF THE PRESCRIPTION MUST BE ATTACHED**	**DATE OF EXAMINATION**:

OPTICAL INFORMATION (SUBMIT COPY OF PRESCRIPTION)

Prescription:	Sphere	Cyl	Axis	Prism	Base	Add
Right						
Left						

EYEWEAR REQUESTED

Description	Cost	Description	Cost	Dispensing	Cost
Frames		High Index		Lenses	
Lens Lab Cost		Contact Lenses		Frames	
Anti Reflective/Tint		Case		Mail	
S/R - Hardex		Repairs		Other	
			GRAND TOTAL		

First Nation Health Authority reserves the right to deny coverage and/or audit the client's provider. Once approved a separate Approval/Denial form will be faxed directly to the provider.