



Review form for Necessary Contact Lenses

Patient Name: _____ D.O.B. ___/___/___
Member SS# _____
Doctor Requesting Lenses: _____ Acct# _____
Doctor's Telephone Number: _____

Reason(s) Contact Lenses are Necessary and not Elective: (Please check appropriate answer)

- Keratoconus
 - Irregular Corneal astigmatism
 - Acuity less than 20/70 with glasses and better than 20/70 with contact lenses
 - Aphakia
 - Anisometropia greater than 3.50 diopters
 - Other _____
-

Spectacle Rx

OD _____ BCVA 20/_____
OS _____ BCVA 20/_____

Contact Lens Rx

OD _____ BCVA 20/_____
OS _____ BCVA 20/_____

Please submit completed form and include your UCR for the following
Fitting fees: _____ and Contact lenses: _____

Attn: Member Services Department
FAX: 410-420-6012 Attn: Tabitha or mail to:

Spectera
2209 Commerce Road, Unit 1
Forest Hill, Maryland 21050
Attention: Member Services Department