# Vision Eligibility Request Form

Fax to: **(833) 540-8649**

| | | | |
|---|---|---|---|
| Provider Name: | | Date: | |
| Office Contact: | | Tax ID: | |
| Phone: | | NPI: | |
| Fax: | | | |

Eligible For*:

| Appointment Date | Member Name | Member ID | DOB | Exam | Frames | Lenses | Comments |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**Please call Customer Service at 833-654-9192 with questions.**

MDwise Staff Initials: _____ Date: _____

** MDwise will complete this section of form and fax back to the provider office.*
*Please allow up to 48 business hours for a return response.*