Clear Form

Minnesota Department of **Human Services**

DHS-4879-ENG 7-11

Minnesota Health Care Programs (MHCP)

Vision Therapy Authorization Form

ASSIGNED NUMBER FROM MN–ITS

Use this form in addition to the MN–ITS Authorization Request transaction or the Authorization Form (DHS-4695) to request authorization for vision therapy. Fax this form with any additional or required documentation to the medical review agent.

Provider Information

PROVIDER NAME	NPI/UMPI
CONTACT NAME	PHONE NUMBER ( )

Recipient Information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	MHCP ID NUMBER

PREVIOUS AUTHORIZATION(S) NUMBER	NUMBER OF USED UNITS	NUMBER OF UNUSED UNITS

REASON FOR CONTINUED NEED

☐ **AMBLYOPIA** (CHECK APPROPRIATE ITEMS)

☐ REFRACTIVE	☐ STRABISMIC	☐ BVA WITHOUT RX OD 20/_____ OS 20/_____	☐ BVA WITH RX OD 20/_____ OS 20/_____	ECCENTRIC FIXATION PRESENT? ☐ YES ☐ NO

☐ **STRABISMUS** (CHECK TYPE TO BEST DESCRIBE)

☐ ESTROPIA	☐ PRISM 6M	☐ PRISM AT 40 CM	☐ EXOTROPIA	☐ PRISM 6M	☐ PRISM AT 40 CM
ARC IS PRESENT ☐ YES ☐ NO			☐ BASIC EXPHORA	☐ PRISM 6M	☐ PRISM AT 40 CM
☐ BASIC ESOPHORIA	☐ PRISM 6M	☐ PRISM AT 40 CM	☐ DIVERGENCE EXCESS	☐ PRISM 6M	☐ PRISM AT 40 CM
☐ CONVERGENCE EXCESS	☐ PRISM 6M	☐ PRISM AT 40 CM	☐ DIVERGENCE INSUFFICIENCY	☐ PRISM 6M	☐ PRISM AT 40 CM

☐ **ACCOMMODATIVE DISORDER** (CHECK ONE TO BEST DESCRIBE)

☐ ACCOMMODATIVE EXCESS	☐ ACCOMMODATIVE INSUFFICIENCY	☐ ACCOMMODATIVE INSTABILITY	☐ BINOCULAR FUSION INSTABILITY	☐ SUSTAINED ACCOMMODATIONS

TEST RESULTS USED TO DETERMINE THAT AN ACCOMMODATIVE DISORDER EXISTS

RECIPIENT'S SUBJECTIVE VISUAL SYMPTOMS (LIST VISUAL COMPLAINTS)

TREATMENT PLAN/PROGRESS (ADDRESS RECIPIENT COMPLIANCE WITH HOME PROGRAM)

SIGNATURE	DATE