



PRESCRIPTION AND AUTHORIZATION FOR FEE BASIS EYEGLASSES

This information is collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, we may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all providers who must complete this form will average 4 minutes. This includes the time to read instructions, gather the necessary facts and fill out the form. The purpose of this form is to allow veterans to purchase their eyeglasses directly by serving as a prescription, authorization and invoice. Although you must submit a bill to receive reimbursement, return of this form is voluntary. Failure to respond will have no adverse effect on benefits to which the provider might otherwise be entitled.

PRIVACY ACT INFORMATION: The information requested on this form is solicited under authority of Title 38, U.S.C., Veterans Benefits, and will be used to determine your eligibility/entitlement and reimbursement of individual claims, and identify your medical records. Additional information may be solicited during the course of processing your application. The information you supply may also be disclosed outside the VA as permitted by law or as stated in the "Notices of Systems of VA Records" 24VA136, published in the Federal Register. Disclosure is voluntary, however, failure to furnish the information will result in our inability to process your request promptly and serve your medical needs. Failure to furnish the information will have no adverse effect on any other benefits to which you may be entitled.

PART I - TO BE COMPLETED BY EXAMINING EYE CLINIC (PLEASE PRINT OR TYPE LEGIBLY)

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| 1. VETERAN'S NAME (Last, first, middle initial) <i>(mandatory)</i> | 2. LAST 4 DIGITS OF SSN <i>(mandatory)</i> |
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PART II - TO BE FULLY COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST

| | | | | | | | | | | |
|--------------------------------------|---|--------------|--------------------|-----------------|--------------------|---------------------------|-------------------|---------|---|---------------|
| DISTANCE | R | 3A. SPHERE | 3B. CYLINDER | 3C. AXIS | 3D. PRISM | 3E. BASE | 3F. BC | 3G. MRP | 4. MEDICAL JUSTIFICATION* | |
| | L | | | | | | | | | |
| NEAR | R | 5A. ADDITION | 5B. HEIGHT | 5C. TYPE | 5D. WIDTH | 5E. NEAR INSET | 5F. TOTAL INSET | 5G. PD | | |
| | L | | | | | | | FAR | | |
| 6A. FRAME NAME | | | | 6B. COLOR | | 6C. MANUFACTURER | | | | |
| 6D. EYESIZE | | | | 6E. BRIDGE SIZE | | 6F. TEMPLE LENGTH & STYLE | | | | 7. ICD-9 CODE |
| 8A. LENSES ONLY | | | 9A. GLASS | | 10A. SINGLE VISION | | 11A. TINT* | | 12. DELIVERY RECOMMENDATION | |
| 8B. USE ENCLOSED FRAMES | | | 9B. PLASTIC LENSES | | 10B. BIFOCAL | | 11B. TRANSITIONS* | | 12A. VETERAN'S RESIDENCE | |
| 8C. FRAME ONLY | | | 9C. SAFETY LENSES | | 10C. TRIFOCAL | | 11C. PROGRESSIVE* | | 12B. EYE CLINIC | |
| | | | | | | | 11D. OTHER* | | 12C. PROSTHETICS | |
| 13. SIGNATURE AND DEGREE OF EXAMINER | | | | | | | | | 14. DATE OF EXAMINATION <i>(mm/dd/yyyy)</i> | |

PART III - TO BE FULLY COMPLETED BY THE PROSTHETIC ACTIVITY OR PROSTHETIC CLERK

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|--|-----------------|--------------------------------|--|----------------------|-------------|------------|
| TO | 15A. CONTRACTOR | 15B. CONTRACT NUMBER | 19. CONTRACT INFORMATION | | | |
| | | | ITEM | CONTRACT ITEM | COST | |
| 16. VETERAN'S ADDRESS (Type name if unclear above) | | | RIGHT LENS | | | |
| | | | LEFT LENS | | | |
| | | | LENS TINT | | | |
| | | | FRAME COMPLETE | | | |
| | | | FRAME FRONT ONLY | | | |
| | | | FRAME TEMPLE RIGHT | | | |
| | | | FRAME TEMPLE LEFT | | | |
| | | | OTHER | | | |
| | | | CASE | | | |
| | | | 17. ORDERING VA MEDICAL CENTER (Name, Address, Symbol) | | | TOTAL COST |
| 20. INSTRUCTIONS TO CONTRACTOR - MAIL TO: | | | | | | |
| VETERAN AT ABOVE ADDRESS | | ORDERING FACILITY - EYE CLINIC | | | | |
| 18. ELIGIBILITY STATUS SC NSC | | | ORDERING FACILITY - PROSTHETIC | | | |
| | | | 21. SIGNATURE AND TITLE OF APPROVING OFFICIAL | | | |

PART IV - TO BE COMPLETED BY CONTRACTOR

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|---------------|---|------------------------------------|---|
| 22. COMMENTS: | 23. THE GLASSES AUTHORIZED HAVE BEEN MAILED TO: | | |
| | THE PATIENT AT THE ABOVE ADDRESS | | |
| | V.A. EYE CLINIC DELIVERY POINT | | |
| | V.A. PROSTHETICS DELIVERY POINT | | |
| | 24. OBLIGATION SYMBOL (order will be rejected unless completed) | 25. ORDER DATE <i>(mm/dd/yyyy)</i> | 26. ESTIMATED DELIVERY DATE <i>(mm/dd/yyyy)</i> |
| | 27. SIGNATURE OF COMPANY OFFICIAL | | 28. DATE <i>(mm/dd/yyyy)</i> |