NOTE: Instructions are written for a multi-part form. Print additional copies as necessary.

OMB Number: 2900-0188
Estimated Burden: 4 minutes
Expiration Date: xx/xx/xxxx

Department of Veterans Affairs

PRESCRIPTION AND AUTHORIZATION FOR FEE BASIS EYEGLASSES

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

1. VETERAN'S NAME (Last, first, middle initial) *(mandatory)*	2. LAST 4 DIGITS OF SSN *(mandatory)*

PART II - TO BE FULLY COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST

		3A. SPHERE	3B. CYLINDER	3C. AXIS	3D. PRISM	3E. BASE	3F. BC	3G. MRP	4. MEDICAL JUSTIFICATION*
DISTANCE	R								
	L								
		5A. ADDITION	5B. HEIGHT	5C. TYPE	5D. WIDTH	5E. NEAR INSET	5F. TOTAL INSET	5G. PD	
NEAR	R							FAR	
	L							NEAR	

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
M.D./O.D.	*(mm/dd/yyyy)*

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

TO	15A. CONTRACTOR	15B. CONTRACT NUMBER

16. VETERAN'S ADDRESS (Type name if unclear above)

17. ORDERING VA MEDICAL CENTER (Name, Address, Symbol)

18. ELIGIBILITY STATUS ☐ SC ☐ NSC

19. CONTRACT INFORMATION

ITEM	CONTRACT ITEM	COST
RIGHT LENS		
LEFT LENS		
LENS TINT		
FRAME COMPLETE		
FRAME FRONT ONLY		
FRAME TEMPLE RIGHT		
FRAME TEMPLE LEFT		
OTHER		
CASE		
TOTAL COST		

20. INSTRUCTIONS TO CONTRACTOR - MAIL TO:

☐ VETERAN AT ABOVE ADDRESS ☐ ORDERING FACILITY - EYE CLINIC ☐ ORDERING FACILITY - PROSTHETIC

21. SIGNATURE AND TITLE OF APPROVING OFFICIAL

PART IV - TO BE COMPLETED BY CONTRACTOR

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 *(mm/dd/yyyy)*	26. ESTIMATED DELIVERY DATE *(mm/dd/yyyy)*

27. SIGNATURE OF COMPANY OFFICIAL	28. DATE *(mm/dd/yyyy)*