Patient Referral Form

Name: ______________________ DOB: ____________ Gender: F / M

Address: ____

City: ________________ State: ____________ Zip Code: __________

Home phone: ________________ Cell phone: ________________

Preferred contact (if not patient): ______________________________

Insurance 1: ______________________ ID# ________________

Insurance 2: ______________________ ID# ________________

Veteran? Y / N

Referred By:

Physicians Name: ________________ Phone: ____________ Fax: __________

Referral Date: ________________ Affected Eye: Right / Left / Bilateral

Reason for Referral: ____

____

Please include most recent visit note with this referral form.

Send by fax or email to:

F: 704-510-9881 E: admin@seocularist.com

CHARLOTTE LOCATION
8426 Medical Plaza Drive # 500
Charlotte, NC 28262
704.510.9292

MT. PLEASANT LOCATION
1300 Hospital Drive #260
Mt. Pleasant, SC 29464
843.884.7113

704.510.9881 | www.seocularists.com

Mailing Address: 3020-I Prosperity Church Rd #638, Charlotte, NC 28269

RX/WRITTEN ORDER
FOR OCULAR PROSTHESIS

**THIS IS NOT A STAND-ALONE DOCUMENT. IT MUST BE ACCOMPANIED BY MEDICAL RECORDS TO SUBSTANTIATE MEDICAL NECESSITY (OPERATIVE REPORT, CLINICAL NOTES AND/OR PHYSICIAN RECOMMENDATIONS). **

PATIENT NAME, ADDRESS, Phone, DOB and MEDICARE ID #	**SUPPLIER NAME, ADDRESS, TELEPHONE and NPI #** Southeastern Ocularists, Inc 8426 Medical Plaza Dr, Ste 500, Charlotte, NC 28262 1300 Hospital Dr, Ste 260, Mount Pleasant, SC 29464 NPI# 1033396551 / 1841213196 Phone# 704-510-9292 Fax# 704.510.9881

ORDER APPLIES FROM: ____________ TO: ____________ OR ☒ LIFETIME | PLACE OF SERVICE 11 / 12

DIAGNOSIS CODES:

	ICD-10:
☐ Other Anophthalmos	Q11.1
☐ Microphthalmos	Q11.2

PROCEDURE CODES: (SOME CHECKED CODES ARE FOR FUTURE USE, IF NECESSARY)

	Code	Description
☒	**V2623**	**Ocular prosthesis, plastic, custom** (Utilized in the enucleated or anophthalmic socket to prevent contraction of tissues)
☒	**V2624**	**Polishing of ocular prosthesis 1-2x/year as needed** (Utilized to resurface a prosthesis for dullness, scratches, and/or protein deposits)
☒	**V2625**	**Enlargement of ocular prosthesis** (Utilized to refit a prosthesis when normal changes of the socket or globe has occurred requiring enlargement of a prosthesis)
☒	**V2626**	**Reduction of ocular prosthesis** (Utilized to refit a prosthesis when normal changes of the socket or globe has occurred requiring reduction of a prosthesis)
☒	**V2627**	**Scleral cover shell prosthesis** (Utilized in the eviscerated, phthisical or microphthalmic socket or when a partial or completely blind globe requires rehabilitation)
☒	**V2628**	**Therapeutic temporary conformer** (Utilized post operatively to develop socket depth or to rehabilitate a microphthalmic/anophthalmic socket)

PHYSICIANS NAME, ADDRESS, TELEPHONE

PHYSICIAN NAME: ______________________________

ADDRESS: ______________________________

____

T: ____________________ **F:** ____________________

PHYSICIAN'S SIGNATURE: ____________________ NPI# ____________________

DATE: ____________________

Signature and Date Stamps Are Not Acceptable

CMS requires that a copy of this order appear in the records of both the referring provider and the ocularist.