PEBTF

Pennsylvania Employees Benefit Trust Fund

150 South 43rd Street • Suite 1
Harrisburg, Pennsylvania 17111-5700

Local 717-561-4750
Toll Free 800-522-7279
www.pebtf.org

CERTIFICATION FOR MEDICALLY REQUIRED VISION CARE BENEFIT

THIS SECTION TO BE COMPLETED BY PATIENT

1. Subscriber Social Security Number_____
2. Subscriber Name: First_____, Middle_____, Last_____
3. Subscriber Address:_____
4. Home Phone Number:_____ Work Phone Number:_____
5. Patient Name: First_____, Middle_____, Last_____
6. Patient Date of Birth: _____
7. Relationship of Patient to Subscriber: _____
8. Please describe medical reason for requesting vision benefits at this time:_____

_____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
Patient Signature Date

** NOTE: The PEBTF requires that this certification be completed before any consideration will be made for payment by the vision care benefit administrator for this benefit.

The following information cannot be provided by the patient's eye care professional but must be provided by the medical doctor treating the patient's medical condition:

1. DIAGNOSIS of physical condition (not eye condition) _____
2. Please explain how physical condition will affect vision _____

_____

3. Has condition stabilized so that a vision analysis would be accurate at this time?
   ☐ YES ☐ NO
4. Is patient currently using medication for treatment of medical condition?
   ☐ YES (List Medications)_____
   ☐ NO
5. Will continued use of medication alter prescription requiring frequent lens changes?
   ☐ YES ☐ NO

PHYSICIAN NAME:_____ _____
SPECIALTY

ADDRESS: _____ _____
PHYSICIAN SIGNATURE

_____ _____
DATE

PHONE NUMBER:_____

This section for NVA use only: **Initials**_____ **Date**_____

CERTIFICATION: ☐ **APPROVED ON**_____ **Services available on:**_____

☐ **DECLINED ON**_____ **Reason for denial**_____

_____

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INFORMATION REGARDING THE CERTIFICATION FOR MEDICALLY REQUIRED VISION CARE BENEFIT FORM

This form is only applicable for special consideration for lenses prior to your two year eligibility date.

Lenses are available for an eligible employee and dependents (age 16 and over) twelve months from the previous date of lens services if medical certification is obtained from and authorized by National Vision Administrators (NVA). Lens changes that are required because of the medical conditions of diabetes or hypertension will be considered for coverage. Please note that coverage for frames is limited to twenty-four months from the date of the last covered frame or contact lens service.

In addition to the portion of the form the employee must complete, a portion must be completed by the physician who is treating the medical condition. Because any visual change must be secondary to a physical condition, the form cannot be completed by your optometrist or ophthalmologist. Upon receipt of the completed certification form, consideration will be given to your request for additional services. Once your request is approved, you will receive approved copies of the certification form.

If you use a participating vision care provider, please give one copy of the certification form to the provider when obtaining your vision care services. In applying for direct reimbursement, you must send a copy of the approved medical certification form to NVA along with your signed itemized receipts for your services.

If you have any questions regarding this benefit procedure, please contact NVA at 1-800-672-7723.

Mail the completed form to:
NVA
Attn: Claims Department
P.O. Box 2187
Clifton, NJ 07015