OLDMUTUAL

OPTICAL PRE-AUTHORIZATION FORM

Provider Name: Branch:

Employer/Scheme:

Principal Member: M/No.

Patient Name: Mobile: DOB:

Referring ophthalmologist:

(where applicable and attach prescription)

Diagnosis

LENS DETAILS

NEW R_x : SV NV DBF PROG

EYE	SPHERE	CYL	AXIS	ADD
R.E				
L.E				

DATE OF LAST REPLACEMENT

OLD R_x : SV NV DBF PROG

EYE	SPHERE	CYL	AXIS	ADD
R.E				
L.E				

Full Description of lenses given (i.e Brand, Index, Photo, MAR)

Specific reason for giving Tint, Photochromatic or Antiglare

NEW FRAME MAKE

Plastic Metal

Rimmed Half Rimless

OLD FRAME MAKE

Plastic Metal

Rimmed Half Rimless

BRAND	MODEL	SIZE	COLOR

Reason for new spectacles (tick as many as may apply)

First time vision correction Prescription change Frame/Lenses breakage beyond repair

Lost Spectacles Replacement of old pair Others (Please Fill)

CHARGES

	COST
Lenses	
Frame	
Extras(Specify)	
TOTAL	

DECLARATION:

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my provider regarding this claim.

Signature of member Date

Optometrist name Sign Date

STAMP OF PROVIDER

UAP INSURANCE COMPANY LIMITED

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