ForeseeHOME™ AMD Monitoring Program by NOTAL VISION™

# PHYSICIAN ORDER FORM

Date: _____

**PATIENT INFORMATION (Mandatory)** Gender: ☐ Female ☐ Male D.O.B. _____

Last Name | First Name | Middle Initial

Preferred Language: ☐ English ☐ Spanish Other: _____

**Must attach patient's Face Sheet OR complete the information below and attach copies of insurance cards.**

Street Address | City | State | Zip

Phone Number | Email

Primary Insurance | Member ID | Group #

Secondary Insurance | Member ID | Group #

☐ Copy of insurance card(s) included

**I am the treating physician for and have examined the above named patient and am ordering the ForeseeHome AMD Diagnostic Program based on my examination as I indicate below:**

| OD (Right eye) | Bilateral | OS (Left eye) |
|---|---|---|
| ☐ **H 35.31 1 2 Dry Intermediate, Right Eye** | ☐ **H 35.31 3 2 Dry Intermediate, Bilateral** | ☐ **H 35.31 2 2 Dry Intermediate, Left Eye** |
| ☐ BCVA 20/60 or better | ☐ OD (Right) BCVA 20/60 or better | ☐ BCVA 20/60 or better |
| | ☐ OS (Left) BCVA 20/60 or better | |

## ORDERING PHYSICIAN INFORMATION/SIGNATURE

*By placing this order, I acknowledge that I have read and understand the "Notal Vision Diagnostic Test Service Physician/Practice Responsibilities" and hereby attest that the information contained in this order is accurate and correct.*

Print Physician Name | Physician Signature

Practice Name | Office Location | Practice Phone Number

**As a diagnostic healthcare provider and HIPAA covered entity, Notal Vision is dedicated to maintaining the privacy and security of every patient's health information.**



***Submit this form by Fax – 1-888-341-9400***

***Or mail to Notal Vision, 7717 Coppermine Drive. Manassas, VA 20109. For assistance with this form please call 1-888-910-2020***