PHYSICIAN ORDER FORM

Date: _____________________  Prescription #: _____________________

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)  OS (Left eye)

☐ H 35.31 1 2 (Dry Intermediate, Right Eye)  ☐ H 35.31 2 2 (Dry Intermediate, Left Eye)

☐ BCVA 20/60 or better  ☐ BCVA 20/60 or better

☐ H 35.31 3 2 (Dry Intermediate, Bilateral)  *Please check appropriate BCVA above

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 – 888-341-9400, email – adminassist@notalvision.com. Or mail to Notal Vision, 7717 Coppermine Drive, Manassas, VA 20109. For assistance with this form please call 877-322-2207.