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, email – adminassist@notalvision.com.
Or mail to Notal Vision, 7717 Coppermine Drive. Manassas, VA 20109. For assistance with this form please call 1-888-910-2020.