



Thank you for your referral!

Please complete the forms below and send with recent chart notes!

**Patient Information**

First Name	Last Name	Date of Birth
Parent/Guardian Name (if any)		
Phone	Email	

**Referring Office Information**

Physician	
Office Contact	Email
Phone	Fax

Thank you and we appreciate the opportunity to share in the care of your patient!

Please send forms and chart notes to

[info@nweyedesign.com](mailto:info@nweyedesign.com)

Fax 425-823-1522



OCULARISTS

Todd Cranmore, BCO BADO  
Christie Erickson, BCO BADO  
Tawnya Cranmore, Apprentice

\_\_\_\_\_  
Patient Name

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DOB

This is a written prescription for the services the above mentioned patient requires.

- L9900 (Orthotic and Prosthetic Supply, Accessory)
- V2623 (Custom Ocular Prosthesis)
- V2624 (Orbital Exam and Polish)
- V2625 (Enlargement of Ocular Prosthesis)
- V2626 (Reduction of Ocular Prosthesis)
- V2627 (Custom Scleral Shell)
- V2628 (Fitting and Fabrication)
- V2629 (Prosthetic Eye, Other Type)
- All of the services above for lifetime care of the patient's prosthesis or shell

Diagnosis: ICD-10:Z44.21 & Z44.22

The above mentioned patient is in need of a prosthesis due to absence or shrinkage of their eye due to birth defect, trauma, or surgical removal. An ocular prosthesis restores the patient's orbit to normal volume and shape, so body functions about the orbit return to normal. The anophthalmic globe will atrophy when not functional. The prosthesis fills both the superior and inferior fornix so a proper flushing of the mucosal fluids will occur. The eye volume is necessary to properly exercise the muscles and orbital contents so there is no atrophy of the anatomical structure throughout the orbit. The purpose of an orbital exam and polish is to help keep protein deposits and bacteria from building on their prosthesis, preventing infection and damage to the prosthetic surface.

I certify the medical necessity of these items for this patient. This form and any statement attached is completed by or reviewed by me.

\_\_\_\_\_  
Physician Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name