SIGHT SCIENCES

Sight Access

CHOOSE THE PRODUCT

The following codes will be evaluated for the patient's benefits:

○ CPT: 66174 Canal/Gonio, 65820 Gonio Only

○ CPT: 65820 Gonio Only

○ CPT: 0563T

CHOOSE THE SERVICE

○ **PRE TREATMENT**
(Support for Benefits Verification, Prior Authorization, PreDeterminations)
NOTE: Benefit Verifications will be faxed back to the number listed in the office contact section.

○ **POST TREATMENT**
(Support for Claims Processing Issue, Denied Claim, or Appeals)
NOTE: Please include the Claim form and EOB for which support is being requested.

PATIENT

PATIENT NAME			DOB
STREET ADDRESS	CITY	STATE	ZIP

INSURANCE **Please complete OR attach a copy of the front and back of the insurance cards.

PRIMARY MEDICAL/HEALTH INS. NAME	PHONE	POLICY ID #	GROUP #
POLICY HOLDER NAME		POLICY HOLDER DOB	RELATIONSHIP TO PATIENT
SECONDARY MEDICAL/HEALTH INS. NAME	PHONE	POLICY ID #	GROUP #
POLICY HOLDER NAME		POLICY HOLDER DOB	RELATIONSHIP TO PATIENT

PRESCRIBER INFORMATION

PRESCRIBER NAME		PRESCRIBER SPECIALTY
NPI	PROVIDER TAX ID	STATE LICENSE #

FACILITY INFORMATION

FACILITY NAME	TAX ID	○ HOSPITAL OUTPATIENT ○ ASC ○ PHYSICIAN OFFICE	
STREET ADDRESS	CITY	STATE	ZIP
OFFICE PHONE	OFFICE FAX		

TREATMENT INFORMATION

DX CODE	○ RIGHT EYE ○ LEFT EYE ○ BOTH
IS THIS PROCEDURE BEING PERFORMED WITH CATARACT REMOVAL? ○ YES ○ NO	ANTICIPATED TREATMENT DATE

OFFICE CONTACT

OFFICE CONTACT NAME	OFFICE CONTACT PHONE
OFFICE CONTACT EMAIL	FAX # FOR SUMMARY

ATTESTATION

☐ By checking this attestation, I certify the following: (1) that I am the prescribing physician and/or the delegate authorized to fill out this enrollment form on their behalf; (2) that the person identified on this Enrollment Form is my patient; (3) in my medical judgement, the treatment information for this patient was medically reasonable and necessary; (4) to the best of my knowledge the information provided by the patient is accurate and complete; (5) that I have received the appropriate permission from the patient to release above information for the purposes of verifying insurance coverage, prior authorization requirements, and, if needed, claim or denied claim support for Sight Sciences products

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