ForeseeHOME™ AMD Monitoring Program provided by Notal Vision Diagnostic Clinic

PHYSICIAN ORDER FORM

PATIENT INFORMATION (Mandatory)

Gender: ☐ Female ☐ Male D.O.B. _____

_____

Last Name First Name Middle Initial

Phone Number: _____ ☐ Home ☐ Cell

Email Address: _____

_____

Street Address City State Zip

PATIENT FACE SHEET & COPY OF INSURANCE MUST BE SUBMITTED WITH THIS ORDER
We cannot complete patient enrollment without insurance information

ForeseeHome is indicated for patients with a BCVA of ≥20/60. Please indicate which eye(s) you are ordering ForeseeHome and the BCVA of each below:

☐ **OD (Right Eye): H 35.31 1 2** BCVA: _____

☐ **OS (Left Eye): H 35.31 2 2** BCVA: _____

If bilateral (both OD and OS selected), the H 35.31 3 2 code will be used for referred patients. Please complete appropriate fields above.

ORDERING PHYSICIAN INFORMATION/SIGNATURE

_____

Print Physician Name Physician Signature

_____

Practice Name Office Location Practice Phone Number

The Notal Vision Diagnostic Clinic is a diagnostic healthcare provider and an IDTF HIPAA covered entity. Dedicated to maintaining privacy and security, patient's health information can be shared between the referring physician and HIPAA covered entities. As the referring provider, 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.

Submit this form by Fax to 1-888-341-9400. For assistance please call 1-855-600-3112.