ForeseeHOME™
AMD Monitoring Program

Provided by Notal Vision Monitoring Center

PHYSICIAN ORDER FORM

All fields are mandatory if applicable

PATIENT INFORMATION

Gender: ☐ Female ☐ Male D.O.B. _____

_____

Last Name First Name Middle Initial

Cell Phone (preferred): _____

Home Phone (landline): _____

Email Address: _____

_____

Street Address City State Zip

_____

Primary Insurance Member ID

_____

Secondary Insurance Member ID

ForeseeHome is indicated for patients with a BCVA of 20/60 or better. 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 Monitoring Center is a 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" online and hereby attest that the information contained in this order is accurate and correct.

Submit this form by fax to 1-888-341-9400 or email practicesupport@notalvision.com.

For assistance please call 1-855-600-3112.