Washington State Health Care Authority

Corneal Cross-linking Prior Authorization Form

This is confidential information intended only for the person to whom it is faxed.

Please return this form by Online direct data entry (**hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/prior-authorization-pa**) or fax this form along with the General Information for Authorization (GIA) form (13-835) to Authorization Services at **1-866-668-1214. The GIA form must be page one of your fax (no fax coversheet)**

1 To be completed by clinician

Contact name _____ Phone number (xxx-xxx-xxxx) _____ Fax number (xxx-xxx-xxxx) _____

Provider name _____ Provider NPI number _____

Clinical contact _____ Phone number (xxx-xxx-xxxx) _____ Fax number (xxx-xxx-xxxx) _____

Client name _____ Client ID _____

2 To be completed by clinician

Requesting provider requirements: Ophthalmologist that is classified as board eligible or board certified with the American Board of Ophthalmology

Is the patient pregnant? ☐ Yes ☐ No ☐ N/A

Corneal thickness at thinnest point microns _____ microns
(minimum 350 microns)

Best corrected visual acuity:

OS _____

OD _____

In the last 12 mo, has the patient had an increase of 1 diopter or more in the steepest keratometry measurement? *(if the client is <26 yo, interval can be 3 mo)*

☐ Yes

If yes,

Date: _____ Diopter measurement _____

Date: _____ Diopter measurement _____

☐ No

In last 12 mo, has the patient had an increase of 1 diopter or more in astigmatism?

☐ Yes

If yes,

Date: _____ Diopter measurement _____

Date: _____ Diopter measurement _____

☐ No

In last 12 mo, has the patient had a myopic shift of 0.5 diopter on subjective manifest refraction?

☐ Yes

If yes,

Date: _____ Diopter measurement _____

Date: _____ Diopter measurement _____

☐ No