Government of the District of Columbia
Department of Health Care Finance
Fee-For-Service Medicaid Program

719A Prior Authorization Request

Patient			Prescribing Provider		Servicing Provider	
Beneficiary Name Sade Medicaid			Provider Name John Doctor		Provider Name Eyewear Provider	
DCID Number 71077777			Provider Number 0888888	NPI 1888877777	Provider Number 07777777	NPI 1555555555
Address City, State, Zip 5555 DC Street, NE Washington, DC 22222			Address City, State, Zip 44333 Nursing Home Road, NE Washington, DC 22222		Address City, State, Zip 12000 Brown Road, NE Washington DC 22222	
Telephone Number 202-222-2222	DOB 00/00/0000	SEX F	Telephone Number 202-202-2022		Telephone Number 333-333-3333	

Other Health Insurance Coverage	Requested Service				Beneficiary Location	
	Surgery	☐	DME	☐	Home	X
	Medical	☐	Pharmacy	☐	ICF/MR	☐
	Dental	☐	Eyewear	X	Nursing Home	☐
	Hospice	☐	Other	☐	Hospital	☐
Discharge Date:	Home Health: ☐ Skilled Nurse ☐PT ☐OT ☐SLP ☐HHA ☐Private Duty				Office	☐

Requested Service Data

Diagnosis Code	Procedure Code	Description of Services, DME and Supplies	Time Required	Frequency or Units	Estimated Charges
Use ICD 10	V2025	Deluxe Frame	2 months	1	$80.00
Code for Dx.	V2784	Polycarbonate	2 months	2	$200.00
H52.4	V2203	Spherocylinder Bifocal	2 months	2	$139.00

Justification: Patient is farsighted which is a condition known as presbyopia and also needs a new pair of eyeglasses for vision correction

For Dental Use only

DENOTE THE TEETH ALREADY MISSING BY "X", TO BE EXTRACTED BY"?", X-RAYS TAKEN BY "V"

Q1				FACIAL								FACIAL				Q2
01	02	03	PRIMARY TEETH	04	05	06	07	08	09	10	11	12	13	PRIMARY TEETH	14	15	16
RIGHT				A	B	C	D	E	F	G	H	I	J				LEFT
				LINGUAL								LINGUAL					
				T	S	R	Q	P	O	N	M	L	K				
32	31	30		29	28	27	26	25	24	23	22	21	20		19	18	17
Q4				FACIAL								FACIAL				Q3

For DME, Home Health, Private Duty Use Only

Requesting Physician Certification: I certify that I have documented that a Face-to-Face encounter, related to the primary reason the beneficiary requires Home Health or DME services, occurred on _____between the beneficiary and the allowed prescriber (listed below).

☐Primary Physician ☐ Nurse Practitioner ☐ Certified Nurse Mid-Wife ☐ Physician Assistant ☐ Acute or Post-Acute Physician

Name of allowed prescriber:_____ Title:_____ Date:_____

Durable Medical Equipment Face to Face Regulations

☐ **Any HCPCS code for the following types of DME:** ++Transcutaneous Electrical Nerve Stimulation (TENS) unit ++Rollabout Chair ++Traction-cervical ++Oxygen and Respiratory equipment ++Hospital beds and accessories

☐ Any item of DME that appears on the DMEPOS Fee Schedule with a price ceiling at or greater than $1,000.

☐ Any other item of DME that CMS adds to the list of Specified Covered Items

Signature of the Requesting Provider: I Certify that the services requested are medically indicated and necessary for the health of this patient and that the foregoing information is true, accurate, and complete.

Signature: John Doctor Title: Optician

DATE 07/23/2026