



COUNTYCARE NOW COVERS LASIK

CountyCare has become the first and only Medicaid plan in Illinois that covers LASIK surgery. See below for more information..

▶ ▶ ▶ Your eye care provider **MUST** fill in the LASIK provider evaluation form and send it back to CountyCare for you to be considered for LASIK. ◀ ◀ ◀

What is LASIK surgery?

LASIK is a surgical procedure that is used to correct vision problems by re-shaping the corneas. It can be effective in fixing your vision for distance and astigmatism. It may not be as effective for correcting your vision seeing things near or close up. After surgery, you may no longer need contacts or glasses.

Who's eligible

To have LASIK out must be between 21 and 50 years of age and in good general health. You will go through an eye exam and a refractive exam to determine if you are a candidate. Only a trained eye care doctor can tell you if you are a candidate for LASIK surgery. You must also be a CountyCare member the day of surgery to be covered.

Patients who might be eligible:

- Are 21 to 50 years old
- In good general health
- Have no health issues affecting eyes
- Have no active eye conditions which may affect healing
- Have a stable vision prescription for at least one year
- Do not have severe dry eye or advanced glaucoma
- Are not pregnant or nursing
- Do not have uncontrolled diabetes

Think you may qualify? Here's what to do next:

- 1 Print the LASIK evaluation form below.
- 2 Make an appointment for a general eye exam with an eye doctor who is in the CountyCare network.
- 3 Fill out the first page of the LASIK evaluation form and bring it with you to your appointment.
- 4 Give the form to your doctor, who will fill out the second page and send it back to CountyCare.

If no issues come up on your first eye exam, you will be contacted to schedule a Refractive Eye exam. This is a pre-surgery exam to determine if LASIK is right for you.

**Call CountyCare member services at 312-864-8200
for details or if you have questions.**



LASIK EVALUATION FORM

▶▶▶ Attention Member: Please fill out this side of the form before going to your eye care provider. Your eye care provider must fill out the next page. ◀◀◀

First and Last Name
Preferred Phone

Date of Birth
Preferred Email

Why are you interested in getting LASIK or PRK (Laser Vision Correction)?

Do you understand and accept that laser vision correction may only reduce dependence on glasses and/or contact lenses, and these may be required after the procedure? Yes No

Do you understand that LASIK does not eliminate the need for reading glasses? Yes No

Like all surgical procedures, LASIK has the risk of complications, and even complication-free procedures can result in less than 20/20 vision. Do you understand this, and are you willing to become educated about those risks, accept a reasonable risk, and comply with a schedule of post-surgery medications and follow-up exams so that the procedure can be performed for you in the safest manner? Yes No

How old are the glasses you are currently using? _____

Has your glasses prescription significantly changed in the past year or two? Yes No

If yes, please explain: _____

What medical problems do you have or have you had in the past? _____

Do you have Diabetes? Yes No

If yes, is it well-controlled? _____

Do you have an autoimmune disease (for example, lupus, rheumatoid arthritis, multiple sclerosis, or myasthenia gravis)? Or, do you have collagen vascular disease? Yes No

Are you aware that you are immunocompromised for any reason? (For example, AIDS)? Yes No

Are you currently breastfeeding, pregnant, or planning to become pregnant within the next six months? Yes No

Please list all medications you have taken in the last six months. _____

Are you taking steroids, immunosuppressants, chemotherapy, or Imitrex (sumatriptan)? Yes No

Are you taking isotretinoin or other acne medication? Or, did you use this in the past 6 months? Or do you have the intention to use it in the next 6 months? Yes No

LASIK PROVIDER EVALUATION FORM

▶▶▶ Attention Member: Your eye care provider must complete this form. The form will not be accepted if a provider does not complete it. ◀◀◀

Patient Name	Patient DOB
Provider Name	Provider Phone
Provider Signature	Date of Exam

What is the spectacle correction (please include (Add)?)

OD + x Add +

OS + x Add +

Are you aware of a change in the refraction in the past 1 to 2 years? If so, please elaborate. Yes No

What are the patient's current distance & near manifest refraction?

OD + x Vision: 20/

OS + x Vision: 20/ Add + Vision:

If the patient wears contact lenses, what is the current prescription? OD: _____ OS: _____

Based on your eye examination, please comment on the following:

If vision is not 20/20 or better in each eye, please explain why? _____

Are there signs of significant anterior blepharitis? Yes No

Are there signs of corneal disease? If yes, are they on any therapies? Still symptomatic? Elaborate below. Yes No

Dry Eye	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Corneal Scarring	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Keratoconus/ corneal thinning disorder	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Fuchs dystrophy/ other corneal edema	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Ocular herpes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	

Does the patient have glaucoma or is the patient followed as a glaucoma suspect? If so, list why. _____

Does the patient have cataracts? Yes No Does the patient have retinal disease? Yes No

Do you think the patient has realistic expectations for the LASIK procedure? Yes No

If pachymetry, Schirmer testing, or topography was performed, please share the results: _____