CountyCare
A MEDICAID HEALTH PLAN

COUNTYCARE 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 to see things near or close up. After surgery, you may no longer need contacts or glasses.

Who's eligible?

To have LASIK, you 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 for it to be covered.

Patients who might be eligible:

- Are 21 to 50 years old
- Are 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
- Have corneal thickness of more than half a millimeter
- Have manifest refraction (using positive cylinder) that is between -6 or +5
- Not receiving hormonal therapy of any kind (excluding birth control)

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.

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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

Date of Birth

Preferred Phone

Preferred Email

Member ID

Preferred LASIK procedure location ☐ Stroger Hospital ☐ Provident Hospital

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 (e.g., HIV)? Yes ☐ No ☐

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

Have you been breastfeeding or pregnant within the past six to 12 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 ☐

Are you receiving hormonal therapy (excluding birth control)? Yes ☐ No ☐

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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 NPI Number		Diagnosis	
Reason for referral			
Preferred evaluation location		Referring provider name	
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 ☐	No ☐	_____
Corneal scarring	Yes ☐	No ☐	_____
Keratoconus/ corneal thinning disorder	Yes ☐	No ☐	_____
Fuchs dystrophy/ other corneal edema	Yes ☐	No ☐	_____
Ocular herpes	Yes ☐	No ☐	_____

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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: _____

When the form is complete, please securely email the form to countycarelasik@cookcountyhealth.org.