CERTIFICATION OF VISION SERVICES AND SUPPLIES

Member Medicaid I.D. No.: ________________________ Member Name: ______________________________

Date of Original Exam (If Applicable)		SPHERE	CYLINDER	AXIS	PRISM	ADD	BF TYPE
	R						
	L						

Date of New Exam (If Applicable)		SPHERE	CYLINDER	AXIS	PRISM	ADD	BF TYPE
	R						
	L						

The following services and items were supplied to the above Medicaid member in accordance with HAR 17-1737-76 which addresses vision services:

☐ **Replacement eyeglasses/contacts within a two year period because of loss or damage of original pair;**

☐ **New pair of prescription eyeglasses/contacts within a two year period because of a significant change in prescription as stated in HAR 17-1737-76 (for a change in prescription of (+) or (-) 0.50 diopter, or sphere or cylinder, or 6 degrees in cylinder axis). Please complete both prescriptions above with dates of exams to document change in prescription.**

☐ **Special lenses and /or coatings are also prescribed in accordance with HAR 17-1737-76 as noted in memo:**

- **Trifocal lenses: ____**
- **Bilateral plano glasses as safety glasses: ____**
- **Transitional lenses: ____**
- **Polycarbonate lenses: ____**
- **U-V coating: ____**

I attest that the above statements are true and accurate to the best of my knowledge and that my client states that she/he has not received the same services from another provider within the same two year period. I have also followed all guidelines found within HAR 17-37-76-76.

Name of Provider: ___________________________________ Provider Medicaid I.D. No.: ________________

Signature of Provider: ____ Date of signature: ______________

CERTIFICATION FOR VISION SERVICES AND SUPPLIES MUST BE ATTACHED TO CLAIM