



Provision of Low Vision Services and Aids Support Documentation

To facilitate processing of your request for low vision services and aids, this form must be completed. Failure to provide complete documentation will result in automatic disapproval of your request. Do not use abbreviations as their use may result in misinterpretation and possible disapproval. A Vision Services Approval/Order form (DCH-0893) must accompany this documentation. (Exception: High add bifocals do not require prior approval; hence, a completed DCH-0893 should be sent directly to the State's vision contractor.)

Beneficiary's Name

Medicaid ID Number

Based on the Low Vision Evaluation provide the following information:

A. HISTORY

1. History of onset of low vision (including, but not limited to, onset, duration, etiology, and any ocular surgery):

2. Present spectacle correction:

R _____ **VA** _____ **ADD** _____ **VA** _____
L _____ **VA** _____ **ADD** _____ **VA** _____

3. Contact Lenses: (If worn)

Power R _____ **Type R** _____
Power L _____ **Type L** _____

4. Low vision aids presently in use:

Magnifiers: _____ Electronic Projection
Microscopics: _____ Magnifier: _____
Telescopics: _____ Filers/typoscopes/visors: _____
Loupes: _____ Other: _____

5. Relevant Systemic Conditions:

B. BENEFICIARY'S GOALS

C. SUMMARY FINDINGS

1. Ocular Diagnosis(es):
R _____ **L** _____

2. Vision Impairment Diagnosis:
R _____ **L** _____

3. Nature and Extent of Visual Fields:

4. Specifications of best conventional spectacle correction:

At distance	R _____	VA _____
	L _____	VA _____
At near	R _____	VA _____
	L _____	VA _____

D. RECOMMENDED TREATMENT

1. No treatment at this time. Follow-up for monitoring (check one):
 3 Months 6 Months 9 Months 12 Months

2. Referral for medical and/or surgical treatment:

3. Description of Recommended Low Vision Aids:

A. VA	
R _____	L _____
Description, manufacturer and catalog number _____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

B. VA	
R _____ Description, manufacturer and catalog number _____	L _____
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

C. VA	
R _____ Description, manufacturer and catalog number _____	L _____
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

E. OTHER RECOMMENDATIONS - DESCRIBE BENEFITS

F. PROGNOSIS

Signature of Examiner _____

Examiner (Print) _____

Date _____