VISION SERVICES APPROVAL / ORDER COMPLETION INSTRUCTIONS FOR DCH-0893

Michigan Department of Health and Human Services

GENERAL INSTRUCTIONS

The DCH-0893 must be used by Medicaid enrolled vision providers to request Prior Approval (PA) and/or order optical hardware for vision services. MDHHS requests that the DCH-0893 be typewritten to facilitate processing. A fill-in enabled copy of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms. The request for PA must be complete and of adequate clarity to permit a determination of the appropriateness of the service without examination of the beneficiary. The form is generally self-explanatory. The following instructions are to assist in completing the DCH-0893.

Note:

- If prior authorization is required, attach documentation of medical necessity and the detailed training plan (if applicable) pursuant to the Medicaid Provider Manual.
- If applicable, complete and attach form MSA-0891 (Provision of Low Vision Services and Aids Support Documentation).
- If applicable, complete and attach form MSA-0892 (Documentation of Medical Necessity for the Provision of Contact Lenses).

Item	Instructions
1	MDHHS use only
2 - 3	Related to the ordering provider.
4	Provide the date the service and/or hardware is being ordered.
5 – 7	Related to the ordering provider
8 – 9	Related to the prescribing provider
10	Ordering Provider Signature requires a hand-written signature (i.e., a stamped signature is unacceptable).
11 - 15	Beneficiary information which can be obtained from the mihealth card or, for Children's Special Health Care Services (CSHCS) enrollees, from the Client Eligibility Notice.
16	The diagnosis(es) code(s) reflecting the greatest specificity for the diagnosis(es) from the International Classification of Diseases (ICD). If appropriate, each eye's diagnosis(es) must be included.
17 – 21	Relate to services and materials being requested and applicable charges. • Lines 01 through 07 are available for lenses, frames, and/or special characteristics (e.g., prisms, high adds) or other services (e.g., contact lens, orthoptics), if applicable. • Item 18 (Procedure Code) must reflect the appropriate CPT/HCPCS procedure code. • Item 19 (Modifier) must reflect a valid modifier applicable for the listed procedure code. • Item 20 (Quantity) must reflect the appropriate quantity for each procedure code. Each spectacle lens procedure code represents one lens. When requesting approval for, or ordering, a pair of spectacle lenses using the same procedure code, use a quantity of "2." • Item 21 (Charge) is completed only for items without fee screens requiring prior approval. Enter your usual and customary charge.
22 – 24	Relate to the type/style of lens(es) and frame requested.
25	Enter all lens specifications. The width and style must be consistent with the procedure code appearing in Item 18.
26	Additional instructions to the vision contractor necessary for proper fabrication.
27	Specifications from the beneficiary's previous lens(es). This is applicable for diopter changes or replacements, as well as when requesting frames only. **NOTE:** The only time this item is left blank is for initial spectacles.
28 – 29	MDHHS use only.

Submission Instructions

Prior Approval

PA requests should be received by the MDHHS Vision Contract Manager no more than 30 calendar days from the date of order. If received beyond 30 days, the provider must include a detailed explanation of why the form submission was delayed.

The provider should retain a copy of the completed form for their file and **mail or fax** the DCH-0893 to:

MDHHS Vision Contract Manager
Program Review Division
PO Box 30170
Lansing, MI 48909

Fax: 517-335-0075

Upon completion of the PA process, a copy of the DCH-0893 is returned to the provider.

Optical Hardware Order

Orders placed with the vision contractor must be received no more than 30 calendar days after the date of order. If beyond the 30 days, the contractor will return the order to the provider who must explain to the Medicaid Program Review Division why the form submission was delayed and request an exception from the time limit.

When placing an order with the contractor, the provider should retain a copy of the completed form for their file and submit the DCH-0893 to:

Classic Optical Laboratories
3710 Belmont Avenue
PO Box 1341
Youngstown, OH 44501-1341

Telephone: 888-522-2020
Fax: 888-522-2022
Online Address: http://www.classicoptical.com

Note: Optical hardware orders may also be submitted through an online process with the vision contractor. To utilize on-line submission, contact Classic Optical Laboratories for additional information.

VISION SERVICES APPROVAL / ORDER

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1. Prior Authorization Number (MDHHS Use Only)

The provider is responsible for eligibility verification. Approval does NOT guarantee beneficiary eligibility or payment.

2. Ordering Provider Name (Last, First, Middle Initial)	3. Ordering Provider NPI Number	4. Date of Order (MM/DD/YYY)
5. Address (No. & Street, Suite, etc.) City State Zip Code	10. Ordering Provider Certification The patient named below (parent or guardian if applicable) understands the necessity to request vision services and/or prior approval for the vision services indicated. I understand that services requested herein may require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may lead to prosecution under applicable Federal and State law. Ordering Provider Signature	
6. Provider Fax Number 7. Provider Phone Number		
8. Individual Prescribing Provider Name (Last, First, Middle Initial)		
9. Individual Prescribing Provider NPI Number		
11. Beneficiary Name (Last, First, Middle Initial)	12. Birth Date	13. mihealth Card Number
14. Beneficiary Address (No. & Street, Apt./Lot #, City, State, Zip Code)	15. Sex ☐ Male ☐ Female	16. ICD Diagnosis Code

	17. Description of Service(S)	R	L	18. Proc. Code	19. Mod.	20. Quantity	21. Charge
01		☐	☐				
02		☐	☐				
03		☐	☐				
04		☐	☐				
05		☐	☐				
06		☐	☐				
07		☐	☐				

Note: If prior authorization is required, attach documentation of medical necessity pursuant to Medicaid Provider Manual.

22. Lens Type: ☐ Plastic ☐ Glass ☐ Polycarbonate ☐ Lens(es) Only ☐ Frame Only

23. Lens Style: ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Hi Index ☐ Cataract

24. Frame Name	C-Size	Manufacturer	
Color	Eye Size	Bridge Size	Temple Style & Length

25. LENS SPECIFICATIONS

	SPHERE	CYLINDER	AXIS	PRISM POWER & BASE DIRECTION	MRP	
					HORIZONTAL	HEIGHT
R						
L						
	ADD	SEGMENT HEIGHT	WIDTH & STYLE	SEGMENT INSET	TOTAL INSET	PD
R						Far:
L						Near:

26. Special Instructions to Laboratory:

27. PREVIOUS LENS SPECIFICATIONS

	SPHERE	CYLINDER	AXIS	ADD	PRISM/ DIRECTION	LENS STYLE
R L						

MDHHS USE ONLY

28. Review Action: ☐ Approved ☐ Insufficient Data ☐ Approved as Amended ☐ Denied ☐ No Action

29.Consultant Comments	Initials and Date