MDHHS
Michigan Department of Health & Human Services

# 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 Magnifier: _____

Microscopics: _____

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<br>**R**_____ **L** _____<br>Description, manufacturer and catalog number<br>_____ | |
| Describe specific use: | |
| Describe benefit: | |
| Acquisition Cost | Professional Fee |

| B. VA<br>**R**_____ **L** _____<br>Description, manufacturer and catalog number<br>_____ | |
|---|---|
| Describe specific use: | |
| Describe benefit: | |
| Acquisition Cost | Professional Fee |

| C. VA<br>**R**_____ **L** _____<br>Description, manufacturer and catalog number<br>_____ | |
|---|---|
| Describe specific use: | |
| Describe benefit: | |
| Acquisition Cost | Professional Fee |

E. OTHER RECOMMENDATIONS - DESCRIBE BENEFITS

_____

_____

_____

_____

_____

F. PROGNOSIS

_____

_____

_____

_____

**Signature of Examiner** _____

**Examiner (Print)** _____ **Date** _____