Documentation of Medical Necessity for the Provision of Contact Lenses

(This form is to be completed and attached to DCH-0893 when requesting prior authorization for the provision of contact lenses. Prior authorization is NOT required for beneficiaries with aphakia who are under six years of age.)

Beneficiary's Name _____ **Medicaid ID Number** _____

Indicate the diagnosis(es) which best describes the beneficiary's condition:

- ☐ Anirida
- ☐ Anisometropia or Antimetropia
- ☐ Aphakia
- ☐ Irregular Corneas *
- ☐ Keratoconus * (If vision can not be improved to 20/40 or better with eyeglasses.)
- ☐ Other conditions with no alternative treatment (e.g., Aniseikonia (with documentation), Keratoconjunctivitis Sicca)

_____

_____

Diagnosis(es) Code: _____

Current spectacle correction:

R _____ **VA** _____

L _____ **VA** _____

ADD _____

Best spectacle correction:

R _____ **VA** _____

L _____ **VA** _____

ADD _____

Has the beneficiary previously worn contact lenses? ☐ YES ☐ NO

If yes, explain:

_____

Is the beneficiary currently wearing contact lenses? ☐ YES ☐ NO

If yes, indicate reason for new lenses:

_____

Keratometry (diopters)

R _____ @ _____ ; _____ @ _____

L _____ @ _____ ; _____ @ _____

Mire Quality

R _____

L _____

*** A corneal topography for Keratoconus and Irregular Cornea diagnoses may be requested.**

Type of contact lens requested:

A. Hydrogels

	R	L
Power		
Series (Brand Name)		
Additional Specifications		
Manufacturer		
Manufacturer's wholesale cost		

B. Rigid Gas Permeable or Hybrid

	R	L
Base Curve		
Power		
Diameter		
Additional Specifications		
Complete description of contact lens parameters		
Material of the contact lens		
Manufacturer of the contact lens		
Brand Name		
Manufacturer's wholesale cost		
Number of lenses required to provide one-year supply		
Prescription expiration date		

Expected obtainable visual acuity with contact lenses at distance:

R _____ **L** _____

Approximate wearing time per day (specify number of hours):_____ _____

Are eyeglasses to be worn simultaneously, as an over-correction, with the contact lenses? ☐ Yes ☐ No

Provide your assessment of beneficiary's ability to insert, remove, maintain, and wear contact lenses:

_____

_____

_____

_____ _____

Provider's Signature **Provider's Name (Print)**

Date: _____

Authority: Title XIX of the Social Security Act
Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.