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

5. Relevant Systemic Conditions:

B. BENEFICIARY'S GOALS

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C. SUMMARY FINDINGS

1. Ocular Diagnosis(es):

R ____________________ **L** ____________________

2. Vision Impairment Diagnosis:

R ____________________ **L** ____________________

3. Nature and Extent of Visual Fields:

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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:

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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______________________________ **L** ______________________________ Description, manufacturer and catalog number ____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

C. VA	
R______________________________ **L** ______________________________ Description, manufacturer and catalog number ____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

E. OTHER RECOMMENDATIONS - DESCRIBE BENEFITS

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F. PROGNOSIS

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Signature of Examiner ____

Examiner (Print) ______________________________ **Date** ____________________

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