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| --- | --- | --- |
| **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)

|  |  |  |
| --- | --- | --- |
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|  |  |
| --- | --- |
| **Diagnosis(es) Code:** |  |

**Current spectacle correction:** **Best spectacle correction:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **R** |  | **VA** |  |  | **R** |  | **VA** |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **L** |  | **VA** |  |  | **L** |  | **VA** |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **ADD** |  |  |  |  | **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:**

|  |  |  |
| --- | --- | --- |
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| --- | --- | --- | --- | --- |
|  | |  |  | |
| **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.