

Vision Care Eyeglass Patient (Medicaid Client) Certification Form

I, _____, certify that:
(Printed name of Medicaid client)

Check all that apply:

- I was offered a selection of serviceable glasses at no cost to me, but I desired a type or style of eyewear beyond Medicaid program benefits. I will be responsible for any balance for eyewear beyond Medicaid program benefits.

My selection(s) beyond Medicaid benefits were:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

- The glasses that are being replaced were unintentionally lost or destroyed.

- I picked up/received the eyewear.

Medicaid client signature

Witness Signature

Date

Date

Client Medicaid Number

Provider TPI Number

Provider NPI Number