envolve®
Benefit Options

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 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