Medicaid Vision Eyewear Client Certification Form

A. Client Information

1. Client Name:	2. Client Number:

B. Provider Information

1. Provider Name:	2. Provider NPI:

C. Acknowledgement (initial all that apply)

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

My selection(s) beyond Medicaid benefits were:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

I certify that my eyeglasses or contact lenses were lost, stolen, or damaged beyond repair and that I have received instruction on the proper use and maintenance of the eyewear.

I have picked up/received my new glasses or contact lenses.

D. Signature

Printed name of client, parent, or guardian	Printed name of witness
Signature of client, parent, or guardian	Signature of witness
Date of signature	Date of signature