CSHCN Services Program Vision Care Eyeglass Client Certification Form

This form must be kept in the client's file for all eyewear. *Do not submit this form with your claim.*

For help completing this form, call the TMHP-CSHCN Services Program Contact Center at 1-512-514-3000, option 2, or 1-800-568-2413.

Please print or type requested information below.

Client Information

First name:	Last name:
CSHCN Services Program number: 9-____________________-00	Date of birth:
Address/City/State/ZIP:	
Diagnosis:	

Certification

I, ____, certify that:
(Printed name of CSHCN Services Program 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 costing more than the CSHCN Services Program benefit allows. *I will be responsible for any balance.*

My selections of serviceable glasses that cost more than the CSHCN Services Program benefits were:

1. ____
2. ____
3. ____
4. ____

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

☐ I picked up or received the eyewear.

Client, parent, or client representative signature:	Date:
Witness signature:	Date:
Provider signature:	Date:
CSHCN Services Program TPI:	NPI: