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

_____

Provider NPI