Vision Care Eyeglass Patient (Medicaid Client) Certification Form

(Replacement Form)

I, _____ Patient DOB:_____ 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 desire a type of style of eyewear beyond Medicaid program benefits. I will be responsible for any balance for eyewear beyond Medicaid Program benefits.

My selection (s) beyond Medicard benefits were

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

____ The Glasses that are being replaced were unintentionally lost or destroyed.

____ I picked up/received eyewear.

_____ _____
Medicaid client signature/ Guardian Staff signature

_____ _____
Date Date

_____
Client Medicaid Number

_____
Representative Name

_____
Patient Eligibility