

**NF PETI Medical Necessity Certification Form
Eyeglasses (Corrective Lenses) Purchase or Repair Criteria**

Client name _____

Medicaid State ID Number _____

Medical Necessity (Shall be completed by the attending physician)

Circle all appropriate items.

1. Client demonstrates behavior indicative of visual changes or inadequate correction (e.g., stumbling, difficulty finding food on plate, unable to read or see TV, complaints of blurred or unclear vision).
2. Client has history of visual problems with or without correction, and problem affects activities of daily living.
3. Other considerations (circle as applicable):
 - A. Client has the following specific existing visual problems: _____
 - B. Client's corrective lenses have been broken or lost due to no fault of the nursing facility.
 - C. Client's glasses require repair.
 - D. Client owes a balance from a refraction not covered by Medicare/Medicaid or other insurance.
4. Client requests and has the physical and cognitive ability to wear and benefit from corrective lenses.

Facility Instructions

1. The evaluation for corrective lenses (eyeglasses) must be part of a comprehensive general ocular examination conducted by a licensed ophthalmologist or optometrist.
2. Medicare and/or Medicaid shall be billed for any covered services and denied before submittal to the NF PETI program for review.
3. The medical necessity for prescribed corrective lenses shall be based on a comprehensive ocular evaluation/examination and not solely based on the client's refractive status.
4. Purchase of new corrective lenses to replace existing corrective lenses shall include documentation of the reason for replacement.
5. Attach a copy of the itemized statement or treatment plan which includes the procedure code, the diagnosis code and the costs for each item.

Requested NF PETI amount: _____

I certify that I consider the supplies and or services included in this request to be medically necessary and that there are no medical or cognitive contraindications to the provision of the supply/service.

Signature of Attending Physician _____ Date _____ License # _____

Signature of Ophthalmologist _____ Date _____ License# _____

Signature of Optometrist _____ Date _____ License# _____

I agree to the purchase of the supplies and/or equipment covered by this request. I understand that NF PETI may not cover the entire cost.

Signature of Client/Responsible Party _____ Relationship _____

Incomplete forms will be returned for completion.