NEW HAMPSHIRE MEDICAID

For State use only.	APPROVED
Date: ______________	By: ________________
Dates of Service: ________________________	
EPSDT: _____SA #: ______________________	

07/2023

REQUEST FOR SERVICE AUTHORIZATION

NH Medicaid Eyeglass Program

(Fee-for-Service (FFS) Program Only - Not for Managed Care program use)

*****PLEASE PRINT OR TYPE ALL INFORMATION (all fields are required)*****
Must use a separate request form for each discipline

RECIPIENT INFORMATION

RECIPIENT NAME: ________________________________ DATE OF BIRTH: ________________

RECIPIENT MEDICAID ID #: ________________________ DIAGNOSIS (**NOT CODES**): ________________________

MEMBER ADDRESS: ____
STREET CITY, STATE, ZIP CODE

ALTERNATE INSURANCE: NAME OF PLAN: ____

Providers are expected to follow all third party payors requirements for payment and all third party obligations shall be exhausted before billing Medicaid, in accordance with 42 CFR 433.139.

PROVIDER INFORMATION

CONTACT PERSON: ______________________________ EMAIL: ____

TELEPHONE #: ___________________EXT:_________ FAX #:____

REQUESTING PHYSICIAN: ______________________ PHYSICIAN MEDICAID ID #: _________________________

PERFORMING PROVIDER: Classic Optical Lab. PERFORMING PROVIDER MEDICAID ID #:__3080114___

OLD PRESCRIPTION DATE:				NEW PRESCRIPTION DATE:			
	SPHERE	**CYLINDER**	**AXIS**		**SPHERE**	**CYLINDER**	**AXIS**
OD				OD			
OS				OS			
ADD				ADD			

Description of Glasses	**Procedure Code**	☐ Medically necessary.
		☐ Replacement frame or lenses due to damage, one (1) per 12 mos.
		☐ Replacement lost glasses (age 20 and under), one (1) time only.
		☐ Other:

CLINICAL INFORMATION :

Specialty Lenses refer to Fee Schedule
V2025 - Specialty Frame
V2300-V2399 - Trifocal Lenses
V2744 – Photochromic Lenses
V2782 – Hi Index 1.54-1.65
V2783 – Hi index > 1.66

I certify that the requested prescription and glasses are medically necessary and beneficial to the member.

Signature of Provider ***Date***

Printed Name ***Title***

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

PLEASE FORWARD THIS INFORMATION TO ATTENTION - MEDICAID MEDICAL SERVICES BY FAX OR MAIL

129 Pleasant St ■ Concord, NH 03301 ■ Email: ServiceAuthorizationFFS@dhhs.nh.gov ■ FAX: (603) 314-8101