

Document Control Number

1. PROVIDER NAME

2. NPI

3. DOS

4. ADDRESS

5. CITY

STATE

ZIP

6. RECIPIENT NAME (FIRST, MI, LAST)

7. RECIPIENT NO.

8. BIRTHDATE

POWER

PRISM

DPD

NPD

R	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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SPHERE

CYLINDER

AXIS

IN

OUT

UP

DOWN

O.C. HEIGHT

SEGMENT

R	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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ADD

HEIGHT

BASE CURVE

DEC

INSET

TOTAL

LENS MATERIAL

R	<input type="text"/>
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L	<input type="text"/>
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LENS STYLE

check one:

Glass

Plastic

Polycarbonate

ADDITIONAL INFORMATION

FRAME MATERIAL (CHECK ONE):

PLASTIC

METAL

FRAME NAME

FRONT/CHASSIS COLOR

MFG.

EYE

DBL

TPL SIZE

My signature certifies that all entries on this document are true, accurate and complete; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials (responsible for the various aspects of the State's Medical Assistance Program, as provided under Title XIX and Title XXI of the Social Security Act and applicable State statutes); and eyeglasses and/or parts will be dispensed to this recipient within a reasonable time period after receipt from the Department of Corrections.

Signature

Signature Date