WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Medicaid Based on Blindness

Report and Recommendation of State Reviewing Ophthalmologist

MA ID No./Pending Medicaid No.: _____

Name of Applicant _____

Address of Applicant _____

This is to certify that both the original and duplicate copy of the "Report on Eye Examination" on the above case was prepared by:

_____ M.D., of _____

(Name of Examiner) (City) (State)

have been reviewed by me as of this date.

1. Is the material submitted to you sufficient to permit a determination of blindness?
   Yes _____ No _____

2. Does the medical information contained in the report indicate that the applicant meets state requirements of eligibility for Medicaid in accordance with the definition of "economic blindness?"
   Yes _____ No _____

3. Is the patient receiving adequate treatment at this time? Yes _____ No _____

4. What additional information is needed before a decision is made? _____

   _____

   _____

   _____

5. Nature of treatment recommended, if any: _____

   _____

   _____

6. Is referral to any other agency recommended? _____

   _____

   _____

_____ _____

Date Reviewing Ophthalmologist

DFA-B-13a
Rev. 7/04