WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
MEDICAL REVIEW TEAM (MRT)

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)

and 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? _____

_____

_____

_____

_____ _____
Reviewing Ophthalmologist Date

DFA-B-13a
Rev. 10/06