

**Michigan Department of Community Health**  
**Completion Instructions for DCH-0893**  
**VISION SERVICES APPROVAL / ORDER**

**General Instructions**

The DCH-0893 must be used by Medicaid enrolled vision providers to request Prior Approval (PA) and/or order optical hardware for vision services. MDCH requests that the DCH-0893 be typewritten to facilitate processing. Fill-in enabled copies of this form can be downloaded from the MDCH website [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders) >> Policy and Forms >> Forms. The request for PA must be complete and of adequate clarity to permit a determination of the appropriateness of the service without examination of the beneficiary. The form is generally self-explanatory. The following instructions are to assist in completing some portions of the DCH-0893 that may require clarification.

Item	Instructions
1	MDCH use only.
2 - 6	Related to you and/or your employer.
7	Date of Order
8	Provider Signature requires a hand-written signature (i.e., a stamped signature is unacceptable).
9 - 13	Beneficiary information which can be obtained from the <b>mihealth card</b> or, for Children's Special Health Care Services (CSHCS) enrollees, from the Provider Authorization Notice (form MG-041) or the Client Eligibility Notice (form MG-040).
14	The diagnosis(es) code(s) reflecting the greatest specificity for the diagnosis(es) from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). If appropriate, each eye's diagnosis(es) must be included.
15 – 19	Relate to services and materials being requested and applicable charges. <ul style="list-style-type: none"> <li>▪ Lines 01 through 07 are available for lenses, frames, and/or special characteristics (e.g., prisms, high adds) or other services (e.g., contact lens, orthoptics), if applicable.</li> <li>▪ Item 16 (Procedure Code) must reflect the appropriate CPT/HCPCS procedure code.</li> <li>▪ Item 17 (Modifier) must reflect a valid modifier applicable for the listed procedure code.</li> <li>▪ Item 18 (Quantity) must reflect the appropriate quantity for each procedure code. Each spectacle lens procedure code represents one lens. When requesting approval for, or ordering, a pair of spectacle lenses using the same procedure code, use a quantity of "2."</li> <li>▪ Item 19 (Charge) is completed only <u>for items without fee screens requiring prior approval</u>. Enter your usual and customary charge.</li> </ul>
20 - 22	Relate to the type/style of lenses and frame requested.
23	Enter all lens specifications. The width and style must be consistent with the procedure code appearing in Item 16.
24	Additional instructions to the vision contractor necessary for proper fabrication.
25	Specifications from the beneficiary's previous lens(es). This is applicable for diopter changes or replacements, as well as when requesting frames only. <b>NOTE:</b> The only time this item is left blank is for initial spectacles.
26 - 27	MDCH use only.

Authority: Title XIX of the Social Security Act  
Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.

## **Submission Instructions**

### **Prior Approval**

PA requests should be received no more than 30 calendar days from the date of order. If beyond the 30 days, the provider must include a detailed explanation of why the submission was delayed.

The provider should retain a copy of the completed form for their file and **mail or fax** a copy of the DCH-0893 to:

**MDCH Vision Contract Manager  
Program Review Division  
PO Box 30170  
Lansing, MI 48909**

**Fax: (517) 335-0075**

Upon completion of the PA process, a copy of the DCH-0893 is returned to the provider.

### **Optical Hardware Order**

Orders placed with the contractor must be received no more than 30 calendar days after the date of order. If beyond the 30 days, the contractor will return the order to the provider who must explain to Medicaid why submission was delayed and request an exception from the time limit.

When placing an order with the contractor, the provider should retain a copy of the completed form for their file and submit the DCH-0893 to:

**Classic Optical Laboratories  
3710 Belmont Ave.  
PO Box 1341  
Youngstown, OH 44501-1341**

**Telephone: (888) 522-2020**

**Fax: (888) 522-2022**

**Online Address: <http://www.classicoptical.com>**

**NOTE:** Optical hardware orders may also be submitted through an online process with the vision contractor. To utilize on-line submission, contact Classic Optical Laboratories for additional information.

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1. Prior Authorization Number (MDCH Use Only)
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The provider is responsible for eligibility verification. Approval does NOT guarantee beneficiary eligibility or payment.

2. Provider Name (Last, First, Middle Initial)			8. Provider Certification The patient named below (parent or guardian if applicable) understands the necessity to request vision services and/or prior approval for the vision services indicated. I understand that services requested herein may require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may lead to prosecution under applicable Federal and State law.			
3. Address (No. & Street, Suite, etc.)						
City	State	ZIP Code				
4. NPI Number	5. Phone Number (    )					
6. Provider Fax Number (    )		7. Date of Order (MM/DD/YYYY)		Provider Signature		
9. Beneficiary Name (Last, First, Middle Initial)			10. Birth Date		11. mihealth Card Number	
12. Beneficiary Address (No. & Street, Apt./Lot #, City, State, ZIP Code)			13. Sex <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		14. ICD-9-CM Diagnosis Code	

	15. DESCRIPTION OF SERVICE(S)	R	L	16. PROC. CODE	17. MOD.	18. QUANTITY	19. CHARGE
01		<input type="checkbox"/>	<input type="checkbox"/>				
02		<input type="checkbox"/>	<input type="checkbox"/>				
03		<input type="checkbox"/>	<input type="checkbox"/>				
04		<input type="checkbox"/>	<input type="checkbox"/>				
05		<input type="checkbox"/>	<input type="checkbox"/>				
06		<input type="checkbox"/>	<input type="checkbox"/>				
07		<input type="checkbox"/>	<input type="checkbox"/>				

**Note:** If prior authorization is required, attach documentation of medical necessity pursuant to Medicaid Provider Manual.

20. Lens Type: <input type="checkbox"/> PLASTIC <input type="checkbox"/> GLASS <input type="checkbox"/> POLYCARBONATE <input type="checkbox"/> LENS(ES) ONLY <input type="checkbox"/> FRAME ONLY			
21. Lens Style: <input type="checkbox"/> SINGLE VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> HI INDEX <input type="checkbox"/> CATARACT			
22. Frame Name		C-Size	Manufacturer
Color		Eye Size	Bridge Size    Temple Style & Length

23. LENS SPECIFICATIONS						
	SPHERE	CYLINDER	AXIS	PRISM POWER & BASE DIRECTION	MRP	
					HORIZONTAL	HEIGHT
R						
L						
	ADD	SEGMENT HEIGHT	WIDTH & STYLE	SEGMENT INSET	TOTAL INSET	PD
R						Far:
L						Near:

24. Special Instructions to Laboratory:
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25. PREVIOUS LENS SPECIFICATIONS						
	SPHERE	CYLINDER	AXIS	ADD	PRISM / DIRECTION	LENS STYLE
R						
L						

MDCH USE ONLY	
26. Review Action: <input type="checkbox"/> Approved <input type="checkbox"/> Insufficient Data <input type="checkbox"/> Approved as Amended <input type="checkbox"/> Denied <input type="checkbox"/> No Action	
27. Consultant Comments	Initials and Date