Illinois Department of Healthcare and Family Services

OPTICAL PRESCRIPTION ORDER

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										
L										
	SPHERE	CYLINDER	AXIS	IN	OUT	UP	DOWN	O.C. HEIGHT		

	SEGMENT					
R						
L						
	ADD	HEIGHT	BASE CURVE	DEC	INSET	TOTAL

ADDITIONAL INFORMATION

LENS MATERIAL

R

L

LENS STYLE

check one:

Glass

Plastic

Polycarbonate

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