



AFFILIATED COMPUTER SERVICES

Provider Inquiry Recipient Eligibility for Vision Services

FAX: 907.644.8126

Provider: NPI* or Medicaid Contract ID† _____ Provider Name _____ Date _____
Contact Person _____ Provider FAX _____ Provider Phone _____

Please submit: 1) the recipient name, 2) month and year of service, and 3) at least one other patient identifier such as the recipient Medicaid ID, the SSN, or the Date of Birth (DOB). Provider Inquiry will verify recipient eligibility for the month and year indicated in the Month/Year of Service field, and will indicate if they have received a vision exam or glasses within the last year.

1. _____ (Medicaid or SSN) _____ (Recipient Name) _____ (DOB) _____ (Month/Year of Service) Eligible (Yes) (No) Medicaid _____ (Code) CAMA _____ (Code)
Exam Glasses Neither TPL _____
Services provided within the last year (Code) (Policy Name) (Effective Dates) (Policy No. or Subscriber Group No.)

2. _____ (Medicaid or SSN) _____ (Recipient Name) _____ (DOB) _____ (Month/Year of Service) Eligible (Yes) (No) Medicaid _____ (Code) CAMA _____ (Code)
Exam Glasses Neither TPL _____
Services provided within the last year (Code) (Policy Name) (Effective Dates) (Policy No. or Subscriber Group No.)

3. _____ (Medicaid or SSN) _____ (Recipient Name) _____ (DOB) _____ (Month/Year of Service) Eligible (Yes) (No) Medicaid _____ (Code) CAMA _____ (Code)
Exam Glasses Neither TPL _____
Services provided within the last year (Code) (Policy Name) (Effective Dates) (Policy No. or Subscriber Group No.)

4. _____ (Medicaid or SSN) _____ (Recipient Name) _____ (DOB) _____ (Month/Year of Service) Eligible (Yes) (No) Medicaid _____ (Code) CAMA _____ (Code)
Exam Glasses Neither TPL _____
Services provided within the last year (Code) (Policy Name) (Effective Dates) (Policy No. or Subscriber Group No.)

5. _____ (Medicaid or SSN) _____ (Recipient Name) _____ (DOB) _____ (Month/Year of Service) Eligible (Yes) (No) Medicaid _____ (Code) CAMA _____ (Code)
Exam Glasses Neither TPL _____
Service provided within the last year (Code) (Policy Name) (Effective Dates) (Policy No. or Subscriber Group No.)

COMPLETED BY _____ (ACS Provider Inquiry Specialist) _____ (Date Completed)

* National Provider Identifier

† Formerly known as Alaska Medical Assistance Provider Number