

# Healthy Montana Kids Rx Form

Patient Information and Rx										
Patient Name		<input type="checkbox"/> Mail to Patient	Birth Date		Exam Date		Invoice Number			
Address Street					ICD-9 Dx Code		Order Date			
City	State	ZIP	HMK/CHIP ID		Date Received		Date Shipped			
Sphere	Cylinder	Axis	Prism/Base	Decenter			Distance PD	Near PD		
R										
L										
Add	Near Inset	Total Inset	Seg. Height	OC Height		Center Thickness	Edge Thickness	Bifocal Style		
R								<input type="checkbox"/>		
L										
Lens Information										
Material			Lens Style		Seg. Style		Base Curve			
<input type="checkbox"/> Plastic _____ <input type="checkbox"/> Glass _____ <input type="checkbox"/> High Index _____ <input type="checkbox"/> Polycarbonate _____ <input type="checkbox"/> Other _____			<input type="checkbox"/> SV: <input type="checkbox"/> Bifocal: <input type="checkbox"/> Trifocal: <input type="checkbox"/> Aphakic:				R _____ L _____ Lens Coating/Lens Tint _____			
Scratch Coat <input type="checkbox"/>										
Frame Information										
<input type="checkbox"/> Supply		<input type="checkbox"/> Lenses Only		<input type="checkbox"/> 2nd PR SV		<input type="checkbox"/> Rx Change				
<input type="checkbox"/> ZYL		<input type="checkbox"/> Metal		<input type="checkbox"/> Groove		<input type="checkbox"/> Half Eye				
Frame Name		Color		Eye Size		Bridge		Temple		
						<input type="checkbox"/> AP <input type="checkbox"/> FF		<input type="checkbox"/> SK <input type="checkbox"/> CC		
Manufacturer	Frame or Pattern No.		Frame Measurements				Shape Code	Circumference		
			A.	B.	ED:					
<b>Note: A copy of the member's Healthy Montana Kids ID card must be attached to the prescription order.</b>			Provider name, address, city, state, ZIP (if requested)				Reimbursement by			
							Provider		State	
							Lenses			
							Frame			
							Photo-Chromic			
							Tint			
Ultra Violet										
Scratch Coat										
Tray No.	Provider No.		<b>TOTAL</b>							