

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER:	2. STATE
	12-09 MA (NJ)	New Jersey
<b>TO: REGIONAL ADMINISTRATOR</b> CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL (Check One):		4. PROPOSED EFFECTIVE DATE
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		October 1, 2012

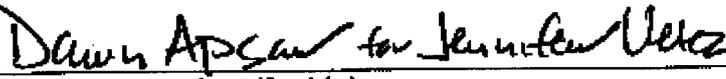
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Social Security Act Section 1903(e)	7. FEDERAL BUDGET IMPACT FFY 2013 [\$0] FFY 2014 [\$0]
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 3.1A page 3 Addendum to Attachment 3.1A page 5a Addendum to Attachment 3.1A page 5a 1 Addendum to Attachment 3.1A Page 6b Attachment 3.1 B Page 3b Attachment 3.1B Page 3a Addendum to Attachment 3.1B Page 5a Addendum to Attachment 3.1B Page 5a1 Addendum to Attachment 3.1B Page 6b Attachment 3.1B Page 3c Attachment 4 19B Page 4	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Same Same New page Same Same Same Same New page Same Same Same

10. SUBJECT OF AMENDMENT:  
**1903 e Option to Cover Optometry Services as Physician Services**

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT     
  OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO: Valerie Harr, Director Division of Medical Assistance and Health Services P.O. Box 712, #26 Trenton, NJ 08625-0712
13. TYPED NAME: Jennifer Velez	
14. TITLE: Commissioner	
15. DATE SUBMITTED:	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: March 20, 2013
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 01, 2012	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Michael Melendez	22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations
23. REMARKS:	