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Notice of Certain Non-Covered and/or Excluded Services, Supplies or Equipment And Patient Agreement to Pay

EYE ASSOCIATES OF SOUTHERN INDIANA
(812) 284-0660 / (888) EYE-CARE

Patient Name: _____ Patient Date of Birth: _____

Date of Notice: _____

You are being provided with this Notice and Waiver for Certain Non-Covered and/or Excluded Services because Provider had determined that services, supplies and/or equipment you have requested from Provider, may be excluded or not covered by your health benefit plan with your insurance company.

Please be advised that your insurance will only pay for services, supplies or equipment that it determines to be medically necessary and/or not experimental or investigational under the applicable insurances policies. If your insurance determines that a particular services is "not reasonable or necessary," "experimental" "investigational", or "not medically necessary" under the applicable insurance health benefit plan and/or policies, or other applicable standards, your insurance will deny payment of that service. If your insurance determines that a particular piece of equipment is a deluxe model and your health benefit plan only covers the standard, your insurance may only make a partial payment up to the amount of the standard benefit. This means that you will be personally responsible for paying Provider for all or a portion of that service, supply or equipment.

The following is a description of the service, supply, or equipment which may be excluded or otherwise not covered under your health benefit plan, as well as the approximate cost you will be responsible for paying the provider as a result of the denial:

REFRACTION $40.00

If you have additional questions about why the above item may not be covered (in whole or in part), please contact your insurances Customer Service at the number located on the back of your insurance card.

PATIENT AGREEMENT TO PAY:

I have been notified by my physician/medical facility/medical equipment supplier that my insurance may deny payment, in whole or part, for the services, supplies and equipment identified above. I understand that I have the right to decide whether or not to receive the services, supplies and equipment identified above. I HAVE DECIDED TO RECEIVE THE SERVICE/SUPPLY. If my insurance denied payment for a service or supply that is not covered under my health benefit plan, I agree to be personally and fully responsible for payment to provider. If your insurance makes a payment in the amount of a "standard" service or supply and I desire to receive a "deluxe" equipment/services. I understand and agree that I am obligated to pay this amount regardless of whatever amount appears as "member responsibility" on any Explanation of Benefits from that I may receive from your insurance.

Patient's Signature: _____

Date of Signature: _____