MARCH® Vision Care

Non-Covered Service Fee Acceptance Form

I _____, a member of _____wish to obtain and pay for _____, a service which is not covered as a covered benefit under the Medicaid/Medicare Program under which I have coverage.

Dr. _____ has explained to me that I will be solely responsible for the cost of _____, which is $_____. I agree to accept responsibility for payment of $_____. I understand that I am not obligated to pay for the above service if it is later found that the service was covered under the Medicaid/Medicare Program under which I have coverage at the time it was provided, even if Medicaid/Medicare did not pay Dr. _____ for the service because he or she did not satisfy Medicaid/Medicare billing requirements.

I acknowledge that I have been given a copy of this agreement.

_____
Member's Signature

_____
Printed Name

_____
Date

FOR OFFICE USE ONLY

Date of Service: ____/____/____
Member's effective date of coverage with primary payor: ____/____/____

- ☐ Member Received Copy
- ☐ Copy placed in Member's Medical Record

Formulario de aceptación del cargo por servicios no cubiertos

Yo _____, miembro de _____deseo obtener y pagar el costo de _____, un servicio que no tiene cobertura como beneficio cubierto en el programa de Medicaid/Medicare bajo el cual tengo cobertura.

El/la Dr(a). _____ me explicó que yo seré el único responsable del costo total de _____, que es $ _____.Acepto responsabilizarme del pago de $_____. Entiendo que no tengo la obligación de pagar por el servicio indicado arriba si posteriormente se determina que cuando se me brindó el servicio sí tenía cobertura en el programa de Medicaid/Medicare bajo el cual tengo cobertura, aunque Medicaid/Medicare no le haya pagado al/a la Dr(a). _____ el servicio porque él o ella no cumplió con los requisitos de facturación de Medicaid/Medicare.

Confirmo que recibí una copia de este acuerdo.

_____
Firma del miembro

_____
Nombre en letra de imprenta

_____
Fecha

FOR OFFICE USE ONLY

Date of Service: ____/____/____
Member's effective date of coverage with primary payor: ____/____/____

- ☐ Member Received Copy
- ☐ Copy placed in Member's Medical Record