A1A FAMILY EYECARE

Medicare Guidelines

GENERAL RULES

The patient must pay an annual deductible toward any qualified health care before Medicare will pay for any services. After the deductible has been met for the year, Medicare will pay 80% of their "approved fee" and the patient pays 20% as a copayment plus any noncovered fees.

If you have supplemental insurance, it may cover the cost of the deductible and copayment. If your supplemental insurance is an approved "Medigap" policy, Medicare will automatically file your supplemental insurance claim for you. Not all supplemental policies are "Medigap" policies. You may be required to file a secondary insurance claim after you have received your Explanation of Benefits from Medicare.

Our Office will file your insurance claim for Medicare and accept payment directly from them if the services qualify for Medicare coverage (see exceptions below). Any charges Medicare will not cover are payable by the patient at each visit.

SPECIAL EXCEPTIONS

1. Medicare does NOT cover the refraction portion of an eye exam. The refraction determines the eyeglass or contact lens prescription. **The cost of this non-covered service is $39.00.** Payment is due at the time the services are rendered.
2. Medicare does NOT cover any services unless the doctor makes a medical diagnosis. If your only diagnosis is myopia, hyperopia, astigmatism or presbyopia, Medicare will not pay for any services.
3. Medicare may deny benefits if they feel you are receiving examinations too frequently, or are receiving exams by more than one doctor for the same illness.
4. Your signature on this form will serve as your "Signature on File" for processing Medicare forms.

Patient Name_____ Medicare ID#_____ Date of Birth___/___/___

Supplemental Insurance Name_____ ID#_____ Group#_____

I HAVE READ AND UNDERSTAND THE ABOVE AND I AGREE TO PAY FOR SERVICES AND MATERIALS THAT MEDICARE DOES NOT COVER. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIANS OR SUPPLIER FOR SERVICES. ADDITIONALLY, I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

Patient Signature_____ Date___/___/___