Medicaid Waiver

Patient's Name_____ RID #_____

Date of Service: _____Physician's Name_____

This waiver is being obtained because your doctor has a reason to believe that your Medicaid plan will not pay for your care today for one or more of the following reasons:

- Package B Medicaid only pays for pregnancy related services. The services and/or supplies you are requesting today are not covered because they are **not** related to your pregnancy, a complication of pregnancy, or emergency services.
- The service and/or supplies you are requesting today require a referral from your Primary Medical Provider to be paid for by your MCE plan. The service can be provided to you free of charge if you request care directly from your Primary Medical Provider. If you still want to obtain care from our office, it will not be covered by your MCE plan and you will be responsible for payment.
- The doctor you are seeing does not participate with your Medicaid plan. This doctor is considered out-of-network. The service can be provided to you free of charge if you contact your Primary Medical Provider for a referral to an in-network doctor. If you still want to obtain care from our office, it will not be covered by your Medicaid and you will be responsible for payment. You may file a grievance appeal with your Medicaid Plan, but you will be required to pay for the service yourself while the appeal is pending.
- The service and/or supply you are requesting exceeds the benefit limitations established by Medicaid and will not be covered. You will be responsible for payment.
- Other, please specify situation and reason for non-coverage:_____

  _____

The following services-supplies (CPT/HCPCS) are not covered for today's visit for the above referenced reason:

CPT/HCPCS	Description	Estimated Fee
_____	_____	_____
_____	_____	_____
_____	_____	_____

"My doctor's office has read this notice to me and answered my questions about non-coverage. I understand that these services will not be covered or paid by my Medicaid plan. I understand this limitation in my coverage but still wish to receive the services/supplies. I agree to be personally and financially responsible for payment for these services."

_____ _____

Patients Signature (or Guarantor) Date

The above noted recipients' benefits limitations and scope of Medicaid coverage were verbally explained and his/her signature was witnessed by:

_____

Staff Signature and Title