2018

NOTICE TO MEDICARE PATIENTS

Our office accepts MEDICARE insurance for your eye care needs. We are happy to file your insurance claim. In the event you have a secondary insurance carrier, MEDICARE will forward a copy of your claim for cross-over coverage.

AS A REMINDER YOU ARE FINANCIALLY RESPONSIBLE FOR THE FOLLOWING:

1) **THE DEDUCTIBLE -** usually this amount is **$183.00** per calendar year for medical care that is paid before Medicare starts its coverage.

2) **CO-INSURANCE -** 20% of the fee for each procedure per visit.
Your secondary carrier may pay these fees for you.

3) **MEDICATIONS/DRESSINGS -** No medications or dressings are approved.

4) **CONTACT LENS SERVICES -** Medicare does not cover normal procedures for contact lens wearers. Medicare may provide contact lens services for Aphakic patients.

5) **OPTICAL SERVICES -** Medicare will cover certain costs of prescription eyeglasses for **AFTER CATARACT SURGERY patients ONLY**. This includes a standard frame and single vision, bifocal or trifocal clear plastic lenses for each eye after surgery.

6) **NON-COVERED CHARGES -** **Refraction**
Deluxe Frame – any amount over Medicare allowable
Lens Additions – tint, scratch coating, anti-reflective coating, progressive lenses or any other special feature
After hours emergency services

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of Medicare Law. In the event Medicare denies payment, I hereby agree to pay all fees (Including, but not limited to the refraction, deluxe frame, special features on lenses or contact lens related services) not covered by Medicare.

A staff member is available for any questions you may have regarding your insurance coverage.

INSURANCE FILING NOTICE

I understand that a claim for all service and/or products rendered to me this date will be filed by this office and submitted to my insurance carrier today. Medicare provides a "complementary crossover" to many, but not all, secondary insurance companies. In the event Medicare does not provide this service to me, I understand that it is my responsibility to file for compensation. I agree to pay any and all fees that are not paid by my insurance providers within 90 days of the date of service. In the event, Vision Square Eye Care does NOT accept my secondary insurance. I understand that I am responsible for that amount at time of service. I am aware that filing for the fees incurred today does not exempt me from responsibility for the fees charged.

I have received the opportunity to ask any questions related to my insurance claim.

_____ _____
Medicare Beneficiary Signature Date

Witness: _____