Community Eye Care of Indiana

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MCE Enrollee Waiver

Patient's Name: _____ RID#: _____ Date of Service:_____
Physician's Name: _____ Provider Number: _____
Medicaid Manager Care Entity (MCE Plan):_____

You are enrolled with a Medicaid Managed Care Entity or Traditional Medicaid. 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:

- Medicaid only pays for pregnancy related services, family planning, pharmacy, transportation, and emergency services if you are enrolled in Package B/pregnancy only. 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 in order to be paid for by your MCE plan. Your Primary Medical Provider was contacted, and he/she will not provide a referral. 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 MCE plan. This doctor is considered out-of-network. Your plan requires prior authorization for out-of-network doctors. Our office called your plan and they will not approve the service. The service can be provided to your 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 MCE plan and you will be responsible for payment. You may file a grievance or appeal with your MCE, but you will be required to pay for your service yourself while the appeal is pending. If you wish to appeal this decision, please ask our office staff for help.
- The service and/or supply you are seeking today requires prior authorization (PA) from your plan. Our office contacted your MCE plan and they will not prior authorize the service and/or supply. If you wish to receive this service, it will not be covered by your plan and you will be responsible for payment. You may file a grievance or appeal with your MCE, but you will be required to pay for the service yourself while the appeal is pending. If you wish to appeal this decision, please ask our office staff for help.
- The service and/or supply you are requesting exceeds the benefit limitations established by your plan and/or 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 for 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 of these services."

Patient's Signature (or Guarantor): _____ Date: _____

The above noted recipient's benefit limitations and scope of Medicaid coverage were verbally explained and his/her signature was witnessed by:_____
Staff signature and title

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