

Ambulatory Services
 Department of Internal Medicine

Medicare Statutory Exclusion Form

Pt. Name: _____
 Address: _____
 _____ City State Zip
 MRN: _____
 DOB: _____
 SSN: _____ SEX: _____
 DOS: _____

We know that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Certain items or services are program or statutory exclusions and will not be reimbursed by Medicare under any circumstances. When you receive an item or service that is not a Medicare benefit, **you are responsible for payment**, personally or through any other insurance that you may have. The fact that Medicare will not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended a service or item not paid for by Medicare. Right now, in your case, **Medicare will not pay for the following services.**

Exclusion	Patient Service Check appropriate box(es)
• Personal comfort items	<input type="radio"/>
• Routine immunization(s); other than pneumococcal, flu and hepatitis B	<input type="radio"/>
• Self-administered drugs and biologicals	<input type="radio"/>
• Cosmetic surgery	<input type="radio"/>
• Routine physical examinations; laboratory tests and X-rays; other than covered screening diagnostic tests (e.g. mammography)	<input type="radio"/>
• Eyeglasses or contact lenses (in the absence of aphakia or surgical removal of cataracts)	<input type="radio"/>
• Eye exams for the purpose of prescribing, fitting or changing eye glasses or contact lenses in the absence of disease or injury to the eye	<input type="radio"/>
• Eye refractions	<input type="radio"/>
• Hearing aids	<input type="radio"/>
• Routine dental services (e.g., care, treatment, filling, removal or replacement of teeth)	<input type="radio"/>
• Supportive devices for the feet	<input type="radio"/>
• Routine foot care (e.g., cutting or trimming of corns or calluses, unless inflamed or infected; routine hygiene; palliative care, trimming of nails)	<input type="radio"/>

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations and rulings.**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

Ask us to explain, if you don't understand, why Medicare won't pay.
 Ask us how much these items or services will cost you - **(Estimated Cost:** _____)

Please Choose **One** Option. Initial **One** Box. **Sign and Date** Your Choice

Option 1. YES. I want to receive these items or services.
 I understand that Medicare will not pay when I receive these items or services. I understand that you will bill me for items or services and payment will be expected in full at the time of service. I understand that my claim still may be submitted to Medicare in order to have an explanation of benefits sent to me or any other insurance. I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision. I have received sufficient information from my physician to make an informed decision to refuse the items or services.

Option 2. NO. I have decided not to receive these items or services.
 I will not receive these items or services.

 Date Signature of patient or person acting on patient's behalf

 Date Signature of witness

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.