Notifier: Pro Eyes Optometry, LLC

Patient Name: WVMC ID:

WEST VIRGINIA MEDICAID ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE

Medicaid does not approve all services, even some care that you or your health care provider have good reason to think you need. We expect that WV Medicaid may not pay for the services indicated below.

___	Contact Lens Fitting	Estimated Cost:_____
___	Retinal Photos	Estimated Cost:_____
___	_____	Estimated Cost:_____
___	_____	Estimated Cost:_____

I understand that I will need to pay for these services at the time they are performed, as WV Medicaid will most likely deny these charges, however, WV Medicaid will billed for these services for an official decision on payment. If WV Medicaid does pay for these services, Pro Eyes Optometry will refund any payments made by the patient, less any co-pays or deductibles.

By signing below I acknowledge that I want to receive the services indicated above.

Patient/Guardian signature Date