ISSAQUAH VISION

Dr. Walter Cassidy Dr. Stephen Cassidy Dr. Erinn Tolomei Dr Christina Schiller

Medicare Coverage Information

As one of our patients age 65 and older, Medicare is your primary health insurance. For your convenience, our office is a participating provider with Medicare. This means that our office bills Medicare for your office visits and tests. Medicare then reviews all submitted claims and if approved, reimburses our office 80% of the approved amount. The remaining 20% (the co-payment) is your responsibility as the Medicare beneficiary. You may also be responsible for the deductible and certain non-covered fees, as described below.

Medicare has a yearly deductible of $183.00 that takes effect each January. If, when we submit our claim, Medicare indicates that your deductible has not yet been met, you will be responsible for that portion of the bill.

By law our office is obligated to bill the patient for all non-covered services.

- Medicare pays 80% of covered services after your deductible has been met.
- Medicare DOES NOT pay for the refraction portion of an eye exam. In our office, the fee for the refraction part of the exam is $103. If we collect the refraction fee at the time of service, we offer a $33 reduction in that fee, reducing the fee to **$70**.

Exceptions & Non-covered Services

Medicare will not pay for any services if the doctor only makes a refractive diagnosis during your exam. For example, if your visit is only to determine your prescription (far or near sighted) and no separate medical diagnosis is made, Medicare will not cover any fee for that visit. Medicare does not cover your glasses, contact lenses or contact lens related fittings unless you have had cataract surgery. However, our office is NOT a contracted supplier for glasses or contact lenses after cataract surgery.

Authorization Statement/Signature

I have read and understand the information above and agree to pay for any services provided which are not covered by Medicare. I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or provider of services rendered.

Patient/Beneficiary Signature: _____ **Date:**_____

Printed Name: _____