Brown Fertility, LLC Medicaid Waiver

PATIENT INFORMATION

PATIENT'S NAME

_____
Last **First** **M.I.**

ADDRESS _____

BIRTHDATE _____/_____/_____ **DAYTIME TELEPHONE NUMBER** _____
Month **Day** **Year**

SOCIAL SECURITY NO. _____ **INSURANCE**_____

Florida Traditional Medicaid Insurance Self Pay Waiver

YOUR MEDICAID PLAN IS LIMITED TO:

- **Family Planning only**
- **Limited to ER services only**
- **Medicare Premium Payment only**
- **Services not covered on Medicaid fee schedule**

I understand my Florida traditional Medicaid insurance is limited. The services I am scheduled to receive are considered a Non-Covered Service under my plan. I have been informed by North Florida OB/GYN that the following service or supply:

_____

_____
is a Non-Covered Service under my Medicaid Plan on the date the service was received. As the service will not be covered under my Medicaid Plan, I agree to pay for the service.

I desire (or desired) to have the service or supply provided.

- **I understand that the charge(s) will not be filed with my insurance**.
- **I will be financially responsible for the total cost of the service.**

Brown Fertility will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance.

SIGNATURE

This waiver is not to be used for Medicare Beneficiaries. Please advise our office if you are covered by Medicare as they require their own Advanced Beneficiary Notice (ABN) is used.

Brown Fertility, LLC Medicaid Waiver

Date: _____

Patient Signature: _____

Parent, Guardian or Legal Representative Signature:_____
Witness Signature:_____

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