

Practice Name
Address
City, State, Zip
Phone Number

Name: _____ HIC#: _____

**NOTICE OF EXCLUSIONS FROM
MEDICARE BENEFITS**

There are items and services for which Medicare will not pay. Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.** When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

- Medicare will not pay for: Non-covered services associated with Toric IOLs
 Because it does not meet the definition of any Medicare benefit.

The purpose of this notice 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, 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.

(Estimated Cost for the non-covered services: \$ _____).

Surgeon's Fee: \$ _____

Surgery Center Fee: \$ _____ (Toric IOL differential)

Medicare does not cover the difference in cost between using astigmatism-correcting intraocular lenses (Toric IOLs) in cataract surgery compared to using conventional IOLs. Astigmatism-correcting IOLs provide restoration of distance vision following cataract surgery and refractive correction of vision due to pre-existing astigmatism, with less dependency on surgical correction eyeglasses, or contact lenses (CMS Ruling 1536-R).

You are responsible for the usual co-payments and deductibles associated with the covered cataract procedure. You are also responsible for all fees associated with the non-covered refractive services required to insert and monitor the astigmatism-correcting IOL and the deluxe IOL differential. The non-covered (refractive) services may include the following:

- Refractions
- Extended surgical evaluation
- Extended office visits
- Corneal mapping, wave scans, additional A-scans or IOLMaster

I have requested that an astigmatism-correcting IOL be implanted during my cataract surgery and accept full financial responsibility for the non-covered services described above.

Patient Signature or Authorized Representative

Date

(Give 1 copy to patient and keep original document in your files)