



**NON-COVERED SERVICES / MATERIALS WAIVER FORM**

IEHP DualChoice Member Name: \_\_\_\_\_

IEHP DualChoice Member DOB: \_\_\_\_\_

IEHP DualChoice Member ID#: \_\_\_\_\_

IEHP DualChoice Provider Name: \_\_\_\_\_

Requested Non-Covered Service(s) and/or Materials (check all that apply):

- |   | FEE      |
|---|----------|
| <input type="checkbox"/> Cosmetic contact lenses and fitting services | \$ _____ |
| <input type="checkbox"/> Non-benefit frames                           | \$ _____ |
| <input type="checkbox"/> Cosmetic tints/lens coatings                 | \$ _____ |
| <input type="checkbox"/> Lenses, other than CR39 and Glass            | \$ _____ |
| <input type="checkbox"/> Other _____<br>(specify)                     | \$ _____ |

Total Charges: \$ \_\_\_\_\_

I request the specified service(s)/materials. I understand that the service(s)/materials are not covered by IEHP DualChoice and/or Medicare/Medi-Cal and are unavailable as a benefit to me. I understand that I am under no obligation to purchase any non-covered service or that in requesting such services or materials, I accept full responsibility of payment for all charges as indicated above.

This waiver does not apply to any IEHP DualChoice /Medicare/Medi-Cal covered benefits. All standards regarding covered benefits are unaffected by the provisions of this waiver.

\_\_\_\_\_  
IEHP DualChoice Member's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
IEHP DualChoice Provider's Signature

\_\_\_\_\_  
Date

*IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.*