Eye Care
ASSOCIATES
A Professional Corporation

MANAGED CARE WAIVER FORM

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Patient Name   Date of birth:

Welcome to our Practice. To ensure that your visit goes smoothly and meets your expectations in every way, we have developed this Managed Care Waiver form to help educate you on the referral process and define your responsibilities.

If you do not have a referral for this visit, please read below and check the statement that best describes your situation.

_____ My referral number for this visit is ______________________. If for any reason this authorization number is incorrect, I understand that I will be responsible for any balance due.

_____ I have <u>not</u> obtained a prior referral authorization from my Primary Care Provider, and I am knowingly self-referring for this visit. I understand that I will be responsible for any balance due.

_____ I have <u>not</u> obtained a prior referral authorization for my Primary Care Provider. I have an insurance plan that allows me to self-refer or be referred by a provider outside the managed care network or my insurance company does not require one. I understand that should a referral be required, I will be responsible for any balance due.

_____ My Primary Care Provider has referred me for this visit. At this time, Eye Care Associates has not received the appropriate referral authorization. I understand that it is my responsibility to contact my Primary Care Provider immediately to confirm and to obtain the authorization number for this visit. I will be responsible for any balance due if the appropriate paperwork is not forthcoming.

THIS FORM NEEDS TO BE COMPLETED AND SIGNED PRIOR TO YOUR VISIT.

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Signature of responsible party   Insurance Certificate Number

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Date