



## Non-covered Services Disclosure Form

**To be completed by Avesis Medicaid Provider rendering Care**

\_\_\_\_\_ has chosen to receive materials  
*Member Name and Medicaid Number*  
 that are above and beyond the benefit covered by Medicaid. I have applied the forty dollar (\$40.00) annual benefit to the purchase price of the materials.

QUANTITY	DESCRIPTION	RETAIL COST

The total amount of material(s) is \$ \_\_\_\_\_ (minus \$40) = \_\_\_\_\_.

\_\_\_\_\_  
*Doctor's Signature* *Date*

**To be completed by Member**

I \_\_\_\_\_, have requested  
*Print Your Name*  
 material(s) that are above and beyond the material(s) that are covered by Medicaid.

Read the question and check either YES or NO	YES	NO
I understand this purchase uses my entire \$40 annual material benefit.		
I have chosen to receive these materials not covered by Medicaid.		
I am aware that I am financially responsible for paying for these services.		
I am aware that Medicaid is not paying for these services.		

\_\_\_\_\_  
*Patient's Signature if over eighteen (18) or Parent or Guardian* *Date*

**Providers must report all covered and non-covered CPT/HCPCS codes to Avesis.**