



NON-COVERED SERVICES / MATERIALS WAIVER FORM

MEMBER NAME: _____ MEMBER DOB: _____

MEMBER IEHP ID#: _____

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 _____
(specify) | \$ _____ |

Total Charges: \$ _____

I request the specified service(s)/materials. I understand that the service(s)/materials are not covered by IEHP and/or 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/Medi-Cal covered benefits. All standards regarding covered benefits are unaffected by the provisions of this waiver.

Member's Signature

Date

Provider's Signature

Date