New York Eye and Ear Infirmary of Mount Sinai

New York Eye and Ear Infirmary of Mt. Sinai
310 East 14th Street
New York, NY 10003

Patient Identification Label

Patient Name: _____

Account Number: _____ **Date of Surgery:** _____

Surgeon: _____

NOTICE OF EXCLUSION FROM MEDICARE AND OTHER HEALTH PLAN BENEFITS

Your doctor has recommended cataract surgery with presbyopia and/or astigmatism correction (refractive surgery). The refractive portion of this type of eye surgery is elective or optional.

We expect that your health plan will not cover or pay for the additional cost of the refractive portion of this surgery. (Medicare will not pay for these additional costs).

You are directly responsible for payments to receive items or services that are not covered by your health plan. In order to help you make a choice about the use of one or more of the following items or services during your refractive surgery, we are providing you with the fees that you will be responsible for:

Non-covered Item or Service	Hospital Fee
Surgery using a Femtosecond laser for one of the following: ☐ refractive surgery only ☐ imaging only ☐ both refractive surgery and imaging	$
The incremental cost for the premium intraocular lens (IOL) that corrects for astigmatism and/or presbyopia Lens Model: _____	$

Beneficiary Agreement

I have read this Notice and have had the opportunity to ask any questions and all have been answered to my satisfaction. I understand and accept full financial responsibility for the non-covered items and services described above. I understand my physician may also charge me a separate professional fee for his/her professional services.

_____ _____

Signature of Patient (or Personal Representative) **Date**

ADM NEOMHB

Web Form