Medicare Signature on File

Lantman Eye Care

Dr. Brian R. Lantman
4926 Hwy 58
Chattanooga, TN 37416

As one of our patients 65 and older, Medicare is your primary health insurance. For your convenience, our office is a participating provider with Medicare. This means that our office bills Medicare for your office visit, tests, and materials if you are here for a medical problem. Medicare then reviews all submitted claims and if approved, reimburses our office 80% of the approved amount. The remaining 20% is your responsibility as the Medicare beneficiary. You may be responsible for deductibles and certain non-covered fees as described below.

DEDUCTIBLE—Medicare has a yearly deductible of $140 that takes affect each January. If our office is the first to submit Medicare for you each year, Medicare will notify us that you have not yet met your deductible for the year. Medicare will not pay for you allowable fees until the $140 deductible has been met.

REFRACTION—Medicare DOES NOT pay for refractive services. This is the part of the exam that the doctor determines your prescription. The fee for this service is $40. Medicare WILL NOT pay for any services if the doctor only makes a refractive diagnosis during your eye exam.

GLASSES—Medicare will not cover glasses or contact lenses unless you have had cataract surgery. Medicare will only cover one standard frame and one pair of standard lenses for each eye done. Medicare does not cover deluxe frames. Medicare does not routinely cover lens treatments such as scratch coating, progressive and oversized lenses. These extra charges will be your responsibility. These non-covered items include:

Authorization statement/signature I request that payment of authorized Medicare benefits for any services furnished be made on behalf of me to Dr. Brian R. Lantman. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable for related services.

I have read and understand the information above and agree to pay for any materials and services I order but which are not covered by Medicare.

SIGNATURE_____DATE_____