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
❑ Cosmetic contact lenses and fitting services	$______
❑ Non-benefit frames	$______
❑ Cosmetic tints/lens coatings	$______
❑ Lenses, other than CR39 and Glass	$______
❑ 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