NOTICE OF LIKELIHOOD OF MEDICAID DENIAL

MEDICAID will only pay for services that it determines to be reasonable and necessary under Section 1862 (a)(1) of the Social Security Act. If **MEDICAID** determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under **MEDICAID** program standards, **MEDICAID** will deny payment for that service. I believe that, in your case, **MEDICAID** is like to deny payment for:

____

for the following reason(s): The **MEDICAID** Carrier's Manual states that 12 months must elapse after the month of the last screening. **Example:** If last mammogram was January of 1994, begin counting in February of 1994. **MEDICAID** will reimburse for another screening exam January, 1996.

Please read and sign the following statement:
"I have been informed by my physician that s/he believes that, in my case, **MEDICAID** is likely to deny payment for the services identified above, for the reasons stated. If **MEDICAID** denies payment, I agree to be personally and fully responsible for payment."

Mammogram Screening $90.00

Diagnostic Mammogram $160.00

Signed: ____ Date:______________________