<u>THIS FORM IS MANDATORY FOR ALL PATIENTS.</u>

MEDICAID WAIVER FORM FOR ALL SERVICES

Women's Medical Center of Meridian, P.A.

Date: ___________________________________

<u>Women's Medical Center will NOT ACCEPT Medicaid of Mississippi as secondary insurance for obstetrical care including delivery</u>.

All patients WILL BE responsible for <u>any non-covered services</u> denied by Medicaid which are rendered by Women's Medical Center.

I _________________________________ have read, understand, and agree to the above policy by Women's Medical Center. <u>**I**</u> will be responsible for any non-covered service denied by Medicaid or any service denied for medical necessity by Medicaid of Mississippi.

Patient Signature ____

Guardian Signature (if minor) ____

Witness____

THIS WAIVER IS VALID FOR ALL DATES OF SERVICE.

<u>**ALL PATIENTS**</u> MUST COMPLETE AND SIGN THIS FORM EVEN IF YOU HAVE NO INTENTION OF USING MEDICAID AS A FORM OF PAYMENT.