

Deluxe Item Upgrade Form*

***Please note:** Members enrolled in Medicaid Managed Care (i.e., HMO BlueOption, Blue Choice Option) and Family Health Plus are prohibited from paying out-of-pocket for non-covered upgrades. **Clarification for Vision Providers:** This **does not** impact eyewear purchases for Medicaid Managed Care and Family Health Plus members. Eyewear is covered under their **vision** benefit and is, therefore, not considered DME.

I, _____, understand that my health benefit plan makes payment
(print name) based upon its allowance for covered standard items meeting medical needs.

At an additional cost to me, I may choose to upgrade from a covered standard item to a deluxe item, which may include additional features not covered under my current member benefits.

Please place your initials next to each line before signing.

_____ I have been shown the standard item.

_____ Instead of the available standard item, I choose to upgrade to a deluxe item.

_____ In choosing to upgrade to a deluxe item, I understand that I am responsible for the difference in cost between the retail price of the deluxe item and the retail price of the standard item, plus any applicable deductible and/or copayment and/or coinsurance.

(This area is to be completed by the provider before member signs)

Name of item Electric Breast Pump HCPCS code E0603

Retail price of deluxe item \$ 307.5

Retail price of standard item \$ 178.50

Patient responsibility for upgrade \$ 129.00

(Plus any applicable deductible and/or copayment and/or coinsurance as indicated on your Explanation of Benefits)

_____ Before I signed this document, the durable medical equipment provider completed the information in the box above and has discussed with me all additional costs for choosing to upgrade to a deluxe item. The provider also explained that he/she will provide me with a copy of this completed form for my records.

Member Signature

Date

Member Identification Number *(include three-character prefix)*