CUSTOM AGREEMENT
FOR MEDICAID NON-COVERED SERVICES

Medicaid member name _____

Medicaid ID number _____

I understand the medical service listed below is a service not covered by Medicaid for me. By signing this agreement, I agree to pay this provider for this service to be provided on the date below.

Service(s) I will receive not covered by Medicaid

_____

_____

_____

Date(s) I will receive the services(s) _____

Cost I must pay for the service(s) _____

Member signature _____ Date _____

Provider name _____

Provider address, city, state, zip code _____

Provider telephone number _____

By signing this agreement, provider agrees not to bill Medicaid for services covered by this agreement.

Provider signature _____ Date _____

This agreement must be signed by both the Medicaid member and the provider prior to the member receiving the service(s).

Medicaid member or representative must be legally authorized to sign this document.