Patient Eligibility

1. The applicant applying for assistance must be a US Citizen or Resident Alien and have a valid social security number
2. The applicant must be a New Mexico Resident and reside outside of Bernalillo County
3. The applicant must not receive Medicaid, Medicare, State Coverage Insurance (SIC), Social Security (SSA/SSI), or have Third Party Insurance. **Exceptions to those that are in a transitional period awaiting coverage will be reviewed on a case by case basis.**
4. The applicant will be relied upon as a primary source of information about residency and the wages he/she has reported to be correct and truthful.
5. The application will be reviewed by the EEC Administrator and forwarded to the Program Director, Dr. Arup Das, for approval.

What is covered?

Covered procedures include emergency eye care problems that, if not expeditiously attended to, could result in irreversible vision loss or structural damage to the eye. The majority of procedures provided are laser treatments, retinal reattachments, and treatments for acute eye trauma. The program enables patients to receive a continuity of care with an ophthalmologist of his or her own choosing. This program is the only means by which many persons can obtain eye treatment. Our aim is to return those served to their previous activities and prevent the need for expensive rehabilitative services. This program is not an insurance company or a charity.

Exclusions

Exclusions include: cataract removal; oculoplastic or cosmetic procedures; glaucoma (except Neovascular glaucoma); office visits, diagnostics.

Process

1. When a Provider refers a patient to receive assistance from the program, the physician will complete the Referral Letter and the patient will complete the Financial Eligibility Form. Provider should keep a copy of proof of residency. The provider will fax the referral letter, financial eligibility sheet(s), and office notes along with a fax cover sheet to (505) 272-6125.
2. Once the referral has been reviewed, an approval (or denial) letter will be faxed back to the provider with the approved CPT codes and payment amounts listed. Providers opting to accept approved funds as payment in full for the procedure, facility and anesthesia fees will send a fax notifying the program that the procedure will be scheduled.
3. Once the procedure has been completed, the provider must send the operative/procedure report and the CMS 1500 claim forms to the program.
4. When a repeat procedure is approved for funding, it will be billed at 70% of the original fee.
5. No Balance Billing between provider or hospital and patients permitted.
6. Your participation in the program signifies acceptance of these guidelines.