



MICHIGAN DEPARTMENT OF COMMUNITY HEALTH CO-PAYMENTS REQUIREMENTS

The co-payment requirements listed in the table below apply to most¹ Michigan Medicaid fee-for-service beneficiaries age 21 and older and Adult Benefits Waiver (ABW) fee-for-service beneficiaries.² For detailed information about a specific co-payment requirement, refer to the [Medicaid Provider Manual](#). Exceptions to some co-pay requirements may apply and are noted in the table. There are no co-payment requirements for the Maternity Outpatient Medical Services (MOMS), Plan First! Family Planning Waiver, or Children's Special Health Care Services (CSHCS) programs.

Providers may not refuse to render service if a beneficiary is unable to pay the co-payment amount at the time the service is provided, nor can they refuse to render future services due to unpaid co-payments unless the MDCH provider co-payment policy is followed. Refer to the Medicaid Provider Manual, General Information for Providers Chapter, Billing Beneficiaries Section for details related to the co-payment policy requirements.

SERVICE	MEDICAID CO-PAYMENT ²	ABW CO-PAYMENT ²
Physician Office Visit (including free-standing urgent care clinics)	\$2 ³	\$3 ⁴
Outpatient Hospital Clinic Visit	\$1 ⁵	\$3 ⁶
Emergency Room Visit for Non-Emergency Service No co-pay for emergency services	\$3 ⁷	\$3 ⁷
Inpatient Hospital Stay	\$50	Non-covered service
Pharmacy	\$1 generic drug \$3 brand drug	\$1 all drugs
Chiropractic Visits *	\$1	Non-covered service
Dental Visits	\$3	Non-covered service
Hearing Aids *	\$3/aid	Non-covered service
Podiatric Visits	\$2	Non-covered service
Vision Visits <i>(Effective for dates of service on or after October 1, 2010, eyeglasses and associated vision services will not be covered for beneficiaries age 21 and older except for low-vision (i.e., eyeglasses, contact lenses, optical devices and other related low-vision supplies and services).)</i>	\$2	Non-covered service

* *Effective for dates of service on or after July 1, 2009, these services are no longer covered for Medicaid, CSHCS programs, and MOMS beneficiaries age 21 and older.*

¹ Excluded from the co-payment requirement:

- Medicare/Medicaid dually eligible beneficiaries
- CSHCS/Medicaid dually eligible beneficiaries
- Beneficiaries residing in a nursing facility
- Pregnancy related services
- Family planning related services
- Mental health specialty services and supports provided/paid through the Prepaid Inpatient Health Plans
- Mental health services provided through state psychiatric hospitals, the state Developmental Disabilities Center, and the Center for Forensic Psychiatry
- Services provided by a Federally Qualified Health Center (FOHC), Rural Health Clinic (RHC), or Tribal Health Center (THC)

² Co-payment requirements for Medicaid and ABW beneficiaries enrolled in managed care plans (i.e., Medicaid Health Plan or County Health Plan) may differ from those listed in the table. Contact the appropriate health plan for plan-specific co-payment requirements.

³ procedure codes 99201-99205, 99211-99215, 99385-99387, 99395-99397

⁴ procedure codes 92002-92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397

⁵ revenue code 51x

⁶ procedure codes 99201-99205, 99211-99215, 99385-99387, 99395-99397

⁷ revenue code 451 billed without 452, or revenue code 456