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## PATIENT FINANCIAL RESPONSIBILITY – ALLERGY SHOTS

Patient Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Your doctor is recommending allergen immunotherapy for you.

Please call your insurance company at the Member Services phone number to confirm that this is a covered benefit. Provide the following procedure and diagnosis codes to the insurance company.

Allergy Shot Procedure Codes	
95117	Administration of Injection
95165	Multiple Dose Vials
Allergy Shot Diagnosis Codes	
J30.1	Allergic Rhinitis, due to Pollen
J30.89	Allergic Rhinitis, due to Other Allergen

Are the injections covered? NO  YES  If yes:

Do I have a deductible? NO  YES  \$ \_\_\_\_\_ Deductible met \$ \_\_\_\_\_

Do I have any coinsurance? NO  YES  \_\_\_\_\_%

Do I have a copay? NO  YES  If there is a copay, please contact billing department to discuss billing in bulk.

Is there a maximum/limit to how much is covered? NO  YES  \_\_\_\_\_

The name of the person you spoke with: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ am/pm

Please get a reference number for your call: \_\_\_\_\_

**Please note:** The serum is created specifically for you. If you decide to not initiate the allergen immunotherapy program after the serum has been made, or decide to discontinue the program without consulting the doctor, your insurance company will be billed for the remaining serum. You may be responsible for a portion of the cost.

This form must be completed, signed, and returned to the office prior to starting immunotherapy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_