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PATIENT FINANCIAL RESPONSIBILITY – VENOM SHOTS

Patient Name: _____ Insurance Company: _____

Your doctor is recommending venom shots 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.

Venom Shot Procedure Codes	
95117	Administration of Injection
95145	Single Stinging Insect Venom
95147	Three Single Stinging Insect Venom
95148	Four Single Stinging Insect Venom
95149	Five Single Stinging Insect Venom
Venom Shot Diagnosis Codes	
Z91.030	Bee Allergy Status

Are the shots 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

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: _____

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

Signature: _____ Date: _____