IMPACT MEDICAL
Allergy, Asthma & Immunology

PRIMARY OFFICE
44 Route 23 North, Suite 6
Riverdale, NJ 07457
P: 973-248-9199 | F: 973-248-9299

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 coinsurance? NO ☐ YES ☐ _____%

Do I have a copay? NO ☐ YES ☐ Is 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 ☐ _____

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: _____