ALLERGY MD

Benefits Disclaimer

While our office makes every effort to verify coverage and benefits for your allergy services, insurance companies are becoming increasingly less accurate with their benefit estimates.	**It is our goal to provide you with the best possible care, including cost transparency. However, final insurance determination does not always align with benefits provided by insurance.** **WE DO NOT GUARANTEE BENEFITS**

We strongly recommend that our patients call their insurance plan prior to receiving allergy services (office visit, allergy testing, allergy immunotherapy, etc.) and that a reference number is obtained at the end of the call. While the insurance has the final determination regarding your claim, it can help to have a reference number on file if your insurance company processes the final claim differently than from the benefits provided to you.

The CPT codes to check are:

95004: allergy skin testing **95024:** allergy intradermal testing **95117:** allergy injections **95165:** allergy serum

These codes may both be covered by your copay, your deductible/coinsurance, or one code may be covered by your copay and one by your deductible/coinsurance.

Please select one of the following applicable option below:

1.) ___☐___ I have contacted my insurance plan for my benefits and they are included below. The reference number for my call is: # _____ I am still responsible for my insurance plan's final determination, but this reference number may be used in an appeal. The benefits from my call are as follows:

Specialist office visit goes to my:	_____ copay	_____ deductible/coinsurance	
95004: allergy skin testing goes to my:	_____ copay	_____ deductible/coinsurance	
95024: allergy intradermal testing goes to my:	_____ copay	_____ deductible/coinsurance	
95117: allergy injections go to my:	_____ copay	_____ deductible/coinsurance	(per shot appt.)
95165: allergy serum goes to my:	_____ copay	_____ deductible/coinsurance	(billed yearly)

OR

2.) ___☐___ I am opting to not call my insurance and am aware that I am fully responsible for the amount due once my claim processes. I will be informed of my benefits, but if they differ from the benefits applied to my claim, I understand that I am still responsible for the entire amount due. I understand that I will be responsible for any appeals through member services.
If neither option is selected, we will default to this option.

___☐___ I authorize any balance under $200 to be automatically collected using the card on file without a phone call/email (I will still be able to access patient statements online).

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

By signing this form, I am acknowledging that I am responsible for any copay, deductible, or coinsurance on my insurance plan for any services rendered including, but not limited to, my office visit and AIT services.