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 – 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 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: _____________________