MICHIGAN MEDICINE Allergy and Clinical Immunology **Insurance Waiver for Allergy Immunotherapy**	MRN: NAME: BIRTHDATE: CSN:

Why am I receiving this form?
Note: You received this form because you need to make a choice about receiving the health care items or services below.

Items or Services:
- Allergy Extracts – Insurance CPT code 95145 – 95149, 95165
- Allergy Injections – Insurance CPT code 95115, 95117

Your insurance company may not cover all or any of the cost of the service(s) that are described below. Your insurance carrier only pays for covered items and services when certain rules are met. If your carrier doesn't pay for a particular item or service, that does not mean you should not receive it. The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself.

Before you make any decision about your options, you should do the following:
- Read this entire notice carefully
- We recommend contacting your insurance provider to determine how much coverage you will receive for the injection and if you will be responsible for deductibles or copays.
- Depending upon your insurance carrier, you may be financially responsible for the cost of the preparation and provision of the extract if you do not begin treatment within 12 months.

Please choose only **one option** below by checking **one** box. Then sign and date your choice.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

□ **Option 1. YES. I want to receive these items or services.**
I understand that my insurance carrier will not decide whether to pay unless I choose to receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance company is making its decision. If my insurance carrier does pay, you will refund to me any payments I made to you that are due to me. If my insurance carrier denies payment, I agree to be personally and fully responsible for payment. This means I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance company's decision.

□ **Option 2. NO. I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance carrier and that I will not be able to appeal your opinion that my carrier won't pay.

_____ _____
Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) Date (mm/dd/yyyy)

_____
Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)
Relationship: ☐ Spouse ☐ Parent ☐ Next-of-Kin ☐ Legal Guardian ☐ DPOA for Healthcare

_____ _____ _____
Obtained and Explained by Title Provider No.

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your health information, which your insurance company sees, will be kept confidential.

70-10297	VER: A/25 HIM: 02/25	Medical Record	UNIVERSITY OF MICHIGAN HEALTH MICHIGAN MEDICINE	Financial Responsibility Agreement