allergy & asthma
Medical Group of The Bay Area, Inc.

Adult Allergy

Pediatric Allergy

Clinical Immunology

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# AUTHORIZATION TO MAKE ANTIGEN

**PATIENT NAME _____ DOB_____**

Please read the following information regarding your antigen charges. Almost all insurance plans require that the patient pay a portion of his or her medical services, including the provision of antigen.

Your antigen set is prepared for you individually as prescribed by your doctor, and each set is made to provide you with allergy shots for approximately one year. The majority of our contracting insurance plans require that we submit a claim for antigen **every three months**. Our office will submit these claims for you automatically and you will be billed for any additional co-payments or deductibles as determined by your insurance plan until you complete allergy immunotherapy. **Since your antigen is prepared for you on an annual basis, you are responsible for all charges, even if you discontinue immunotherapy.**

**We will be billing your antigen based on the number of vials required to treat your specific allergies either**

**1 injection, 2 injections or 3 injections or more**

**You will be responsible only for the allowable amount of your personal carrier, and for all copays, coinsurance and deductibles.**

- I understand that my insurance will be **billed quarterly** for antigen maintenance and that I will be responsible for copay and any portion indicated as patient responsibility as indicated on the explanation of benefits.

- I understand that if I do not begin immunotherapy after antigen is authorized to be made, I am responsible for payment of my antigen that has been made specifically for me.

**SIGNATURE_____DATE_____**

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Patient's last appointment: _____. If last appointment greater than 1 year make appointment. New Appointment date: _____

7/13