Revere Health Allergy & Immunology

Tammy Jacobs, MD • Joshua Burkhardt, DO

(Office Only) MRN: _____

PATIENT NAME: _____

DOB: ____/____/_____ **AGE:** _____ **SEX: M / F**

DATE: ____/____/_____

SUBCUTANEOUS IMMUNOTHERAPY (ALLERGY SHOTS) SERUM REFILL FORM

1) **Please fill out completely and return or fax back for refills.**
2) **Please attach or fax the injection record form(s) with this request.**
   ***Please allow 2 weeks for serum refills and delivery.

□ **Please check if you have a Medicaid plan**. This may be a covered benefit of your plan, but currently coverage is limited a certain allotted number of units per 12 month period. After that, we will no longer bill insurance, and you will be responsible for the full cost of the refill serums up front. ***If you have a Medicaid plan, you are required to sign an Advance Beneficiary Notice of Noncoverage (ABN) form attesting that you understand your financial responsibility. Please initial _____.***

Bottle: _____ Dilution: _____ Dose: _____

Bottle: _____ Dilution: _____ Dose: _____

Bottle: _____ Dilution: _____ Dose: _____

Provider:

□ Tammy Jacobs, MD □ Joshua Burkhardt, DO

Office use only:
□ J30.9 Allergen
□ J30.1 Pollen
□ J30.2 Seasonal
□ J30.81 Animals
□ J30.89 Dust mite
□ Z91.048 Mold

If you obtain your injections at another physician office (otherwise leave blank) – Delivery options:

□ Office Pick-up. *If you select office pick-up, but are unable to do so, and need us to mail it out instead, we will require a written statement mailed or faxed to us, with S&H payment prior to shipment (payment can be made over the phone).* ***Please initial _____.***

□ Mail Out to ($25 S&H due prior to shipment): _____
Accepting Physician Address

There are risks to mailing the serum, as the serum may degrade in temperature extremes, thus rendering the serum less effective. Please note that we are also not responsible for lost or damaged serums in the mail. ***Please initial _____.***

Your allergy serum needs to be refilled. In order to refill your serums, we need to have your permission.
Please sign and date below. If you have any questions, please call us at (801) 226-3600.

Signature: _____ Date: _____/_____/_____

Phone: (_____) _____-_____

_____ of Vials $ _____

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DATE: ____/____/_____

Office use only:

Medicaid allowance 30 units (10 units per vial) per calendar year.
Keep track of calendar year below:

Date of initial serum: _____/_____/_____. Number of units (10 units per vial): _____
Current calendar year from date: _____/_____/_____.
Date of refill serum: _____/_____/_____. Number of units (10 units per vial): _____
Date of refill serum: _____/_____/_____. Number of units (10 units per vial): _____
Date of refill serum: _____/_____/_____. Number of units (10 units per vial): _____