



# HARPETH PEDIATRICS

## Updated COVID 19 Vaccine (Moderna)

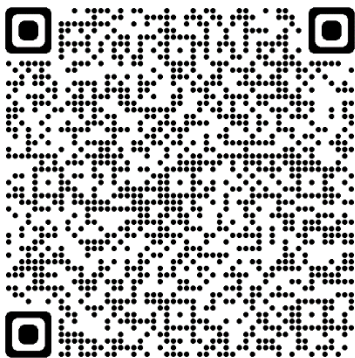
The American Academy of Pediatrics (AAP) recommends coronavirus disease 2019 (COVID-19) vaccination for all infants, children, and adolescents 6 months of age and older who do not have contraindications to receiving a COVID-19 vaccine authorized or approved for use for their age. This includes primary series and/or booster doses as recommended by the CDC. The CDC recommends the 2023-2024 updated COVID-19 vaccines to protect against serious illness from COVID-19.

**Children aged 6 months to 4 years** need multiple doses of COVID-19 vaccines to be up to date, including at least 1 dose of updated COVID-19 vaccine.

**Everyone aged 5 years and older** should get 1 dose of an updated COVID-19 vaccine to protect against serious illness from COVID-19. None of the updated 2023-2024 COVID -19 vaccine is preferred over another.

We have the Moderna COVID-19 vaccine.

Scan this QR code for the Moderna EUA Sheet for 6 months to 11 years.





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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Provider: \_\_\_\_\_

## Advance Beneficiary Notice (ABN)

Payment policies vary by payer and your contract with them. It is important to verify coverage and if possible, confirm it in writing.

Insurance plans do not guarantee payment for your healthcare costs. Insurance plans pay for "covered" services. Even if it is a covered service, it may be applied to your deductible.

The intent of this notice is to help you make an informed choice about whether you want to receive the recommended services, while knowing that you may be responsible for payment. By signing below, you agree to take full financial responsibility if your plan does not cover the below listed items or services.

**\*\* Moderna COVID-19 Vaccine**

**\*\* CPT/Billing codes are 91321 & 90480**

**\*\* Charge for Covid 19 dose is \$175.00 and administration is \$55.00.**

I understand the above listed services may not be covered under my insurance policy. I have been informed of the potential costs of the above services and know that I am financially responsible for all costs not paid by my insurance company.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relation to Patient: