



HARPETH PEDIATRICS

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 pay for the below listed items or services.

**** Respiratory syncytial virus (RSV), monoclonal antibody, seasonal dose; 105 mg/0.7 ml**

**** CPT/Billing codes are 90382 (Enflonsia, Clesrovimab-cfor) and 96380 OR 96381.**

**** Charge for RSV dose is \$865.00 and administration is \$55.00.**

Has the mother of the child received the maternal RSV vaccine? **YES NO**

If yes, when _____ ?

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