

This worksheet will help you determine whether immunizations are a covered benefit under your policy and what portion you may be responsible for.

Patient's Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Time of Call: \_\_\_\_\_ Name of Insurance Representative: \_\_\_\_\_

<b>Description of service</b> (check all that apply)	<b>CPT/HCPC code</b>
<input type="checkbox"/> DT	90702
<input type="checkbox"/> DtaP	90700
<input type="checkbox"/> DtaP-HebB-IPV (Pediatrix)	90723
<input type="checkbox"/> Dtap-Hib (Trihibit)	90721
<input type="checkbox"/> DtaP-Hib-IPB (Pentacel)	90698
<input type="checkbox"/> Hepatitis A vaccine, 2-dose schedule	90633
<input type="checkbox"/> Hepatitis B	90744
<input type="checkbox"/> Hib, 4-dose schedule	90645
<input type="checkbox"/> Hib (ActHIB), 4-dose schedule	90648
<input type="checkbox"/> Hib (Pedvax), 3-dose schedule	90647
<input type="checkbox"/> HPV (Gardasil)	90649
<input type="checkbox"/> Influenza, injection 6-35 months	90657
<input type="checkbox"/> Influenza, injection 3 years +	90658
<input type="checkbox"/> Influenza, mist	90660
<input type="checkbox"/> IPV (polio)	90713
<input type="checkbox"/> Meningococcal (Menactra)	90734
<input type="checkbox"/> MMR	90707
<input type="checkbox"/> MMRV (MMR/Varicella)	90710
<input type="checkbox"/> Prevnar 13	90670
<input type="checkbox"/> Rotavirus	90680
<input type="checkbox"/> Tdap (Adacel)	90715
<input type="checkbox"/> Varicella	90716
<input type="checkbox"/> Other ( _____ )	

Ask your insurance representative:

**Are immunizations a covered benefit under my policy?** Yes / No

**\*If no, ask your doctor about VFC.**

**Do I have a deductible for preventive care/immunizations?** Yes / No

**If yes, has it been met for this child?** Yes / No

**If it hasn't been met, how much is remaining for this child?** \_\_\_\_\_

**Do I have a maximum benefit (benefit cap) for preventive care?** Yes / No

**If yes, has it been met for this child?** Yes / No

**If it has not been met, how much is remaining for this child?** \_\_\_\_\_

**Do I have a co-pay/co-insurance on preventive care services?** Yes / No

**If yes, how much is it?** \_\_\_\_\_