



Patient Chart #:

## Capital Area Pediatrics – FLU/COVID Vaccine Service Authorization

Capital Area Pediatrics remains committed to providing excellent care to our patients and ensuring that our patients and their families remain safe and healthy.

We are providing the information below because you or your child is scheduled to receive the Influenza vaccine and/or COVID-19 vaccine.

The US Food and Drug Administration (FDA) has approved the Influenza vaccine and COVID-19 vaccine for use in patients 6 months and above. While many insurance plans are expected to cover the cost of the vaccines and its administration, there is no guarantee that your insurance company will provide payment.

As a courtesy, Capital Area Pediatrics will submit the claims to your insurance with all appropriate diagnosis codes. However, it is your responsibility to pay for any charges that your insurance denies or applies to cost sharing (copayments, deductibles, or coinsurance).

| Today's Visit                                                                                           | Immunization                                  | CPT   | Vaccine Fee | Administration Fee | Total    |
|---------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------|-------------|--------------------|----------|
|                                                                                                         | Flu Trivalent 0.5cc (6 mos+)                  | 90656 | \$37.00     | \$47.00 (90460)    | \$84.00  |
|                                                                                                         | Covid Vaccine, 0.25ML (Moderna 6 mos –11 yrs) | 91321 | \$194.00    | \$85.00 (90480)    | \$279.00 |
|                                                                                                         | Covid Vaccine, 0.5ML (Moderna 12 yrs+)        | 91322 | \$213.00    | \$85.00 (90480)    | \$298.00 |
|                                                                                                         |                                               |       |             |                    |          |
| <b><i>A 20% discount may be applied to the total amount if paid in full at the time of service.</i></b> |                                               |       |             |                    |          |

I have read and understand the above information. I agree to be responsible for any charges not covered by my insurance.

Date: \_\_\_\_\_

PRINT: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

Name of Legally authorized patient/accompanying adult