Pediatric and Adult Allergy

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PLEASE FAX REQUEST TO * 952-278-6948

ALLERGY SERUM REORDER FORM

➔ ***SERUM CANNOT BE MADE AND BILLED SOONER THAN 6 MONTHS FROM DATE OF LAST SERUM BILLING*** ←

To re-order your serum: Complete, sign and return this form below to our office by mail or fax.

Serum CANNOT be made unless we receive this signed form or written authorization.

Date Requested: ____________________

Patient's Name: ____ Date of Birth: ______________________

Insurance Company: ______________________________ID #:________________ Group #:____________

Vials Needed: 1:1000	1:100	1:10	1:1	(Office use only)
Date of last shot:	Serum:	Concentration:		Dose:

6 month supply___________ 12 month supply___________ (**WILL REQUIRE ALLERGIST APPROVAL**)

Please indicate the office location where you receive allergy shots:

Burnsville_______ Edina_______ outside Clinic_______ (Please complete address below)

Clinic Name: ____ (Outside clinics please fax original shot sheets)

Clinic Address: ____

State: ________________ Zip: ______________ Clinic Phone Number________-_______-________

Name of person making request: ____

Please allow 2 weeks from date requested for this to be processed.
It is my responsibility to verify with my insurance carrier that I have coverage for this service and to obtain any necessary referrals or forms. I understand that I am responsible for any co-pays, co-insurance, deductible, and/or self-pay amounts that may apply.

➔ ***PLEASE NOTE 1:1 (RED) VIALS WILL EXPIRE 1 YEAR FROM WHEN THEY WERE MADE.*** ←

Patient's or Guardian's (if not 18 years of age) Signature: __________________________________

Printed Name: __________________________________