RALEIGH CAPITOL
EAR, NOSE & THROAT

PATIENT NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

Advanced Beneficiary Notice – Sublingual Allergy Drops

NOTE: You need to make a choice about receiving these health care items or services.

Sublingual Allergy Drops are not covered by insurance carriers because drops are considered an "off-label" allergy treatment by the Food and Drug Administration (FDA). Insurance companies do not accept the unlisted code of 95199. Raleigh Capitol Ear, Nose, and Throat will **not** file insurance for Sublingual Allergy Drops.

The cost for Sublingual Allergy Drops is $450.00 for the first 3 months, followed by $375 every 3 months thereafter. You are responsible for payment in full prior to the mixing of your Sublingual Allergy Drops.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you may have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

- Ask us to explain, if you don't understand why your insurance will not pay.
- **Build-up = $450**
  - 3-month supply = 2 escalation vials, 2 maintenance vials, and an initial personalized nurse visit
- **Maintenance refill = $375**
  - 3-month supply = 3 maintenance vials (~$1500/year)

PLEASE CHOOSE **ONE** OPTION. **INITIAL ONE BOX**. SIGN AND DATE YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that my insurance will not cover this service and that Raleigh Capitol Ear, Nose, and Throat will not file a claim for these services. I understand that I am responsible for payment in full for all sublingual allergy drops. I agree to be personally and fully responsible for payment. That is, I will pay personally for these items or services.

☐ **Option 2. NO. I have decided not to receive these items or services**. I will not receive these items or services.

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices.

_____ _____ **DATE** _____
PRINT NAME OF PATIENT ***PATIENT SIGNATURE***

_____ _____ **DATE** _____
PRINT NAME PARENT OR LEGAL GUARDIAN ***PARENT OR LEGAL GUARDIAN SIGNATURE***