RSV Beyfortus Patient Financial Responsibility Form

Care Center Name: _____

Guarantor Information

Name (Parent/Guardian/Representative): _____

Patient Information:

Name: _____

Date of Birth: _____

Acknowledgment and Agreement:

1. I acknowledge that while all Advocare contracted insurance companies generally cover the Beyfortus RSV monoclonal antibody injection, individual insurance plans may have varying coverages.

2. I understand that if the patient's insurance plan does not cover the Beyfortus RSV monoclonal antibody injection, as the Guarantor (named above), I will be financially responsible for both the cost of the injection and its administration.

3. I have been informed and understand that I can contact my insurance provider to verify coverage for this injection using the following CPT codes:

    - 90380 – RSV monoclonal antibody, seasonal dose; 0.5 mL dosage, IM
    - 90381 – RSV monoclonal antibody, seasonal dose; 1 mL dosage, IM

4. If the injection is not covered by the insurance plan, as the Guarantor, I agree to cover the balance owed, up to a total charge of $750 per injection. For children eight months or older who are at high risk, two injections are required at a cost of $750 each (totaling $1,500).

By signing this form, I acknowledge that I read, understood, and agree to the terms and conditions mentioned above and accept full financial responsibility as stated.

Guarantor Signature: _____ **Date:** _____