Frequently Asked Allergy, Asthma & Immunology Billing Questions

How do I obtain an insurance referral?

Many health insurance plans require that patients have an insurance referral authorization number from their primary care provider to see a provider at Boston Children's Hospital. Without an insurance referral, most managed care insurance plans will not pay the hospital and/or provider for the cost of the visit.

Please call your primary care as soon as possible and ask for an insurance referral authorization number to see a doctor at one of our specialty programs on Fegan 6. All insurance referrals should be faxed to 617-730-0062 prior to your visit.

How much will this visit and testing cost?

We can provide you with an estimate for the cost of the visit but the exact amount will only be provided once the visit and documentation are completed. It is only after the claim is sent to your insurance company that the exact amount will be determined.

Will I have to pay for any of the cost for this visit?

Depending on your insurance plan, your health insurance company decides if you are responsible for paying any portion of the charges. Remember that everyone's insurance plan is different. **You may be responsible for paying a co-payment, a deductible, and/or co-insurance based on your health insurance plan.**

What do the terms co-pay, co-insurance, and deductible mean?

Co-Pay - Amount paid by the patient *at the time of the visit* as defined by his or her health insurance plan.

Co-Insurance - Percentage or amount defined in the health insurance plan for which the patient is responsible for paying. For example, the health insurance company may pay 80% of the charges and the patient pays 20%.

Deductible - Amount patient must pay before health insurance coverage starts. For example, a patient could have a $1,000 deductible per year before his or her health insurance starts paying.

Will I have to pay for charges related to testing during my visit?

Depending on your visit, your provider might also want you to see an Allergy Technician for skin testing or patch testing. This will allow your provider to identify any allergies. This will generate a separate charge in addition to the clinic visit charge. The number of allergens being tested is dependent upon each individual patient. The total charges usually vary between $129 and $3,500. In some cases, the visit might be covered by your insurance, but the skin or patch testing might not be covered. It is important that you call your insurance to make sure they cover these costs. For more information on these charges, please see the following page.

What about Allergy shots/Immunotherapy?

If your provider has asked you to start allergy shots/immunotherapy (IT), it is important to understand that the preparation of IT will generate additional charges. Most likely these charges will be covered by your insurance carrier if a referral has been authorized. Each patient receiving IT is billed based upon how many vials the provider has ordered. The majority of patients receive two or more injections at one time and therefore require multiple vials. The first year of IT is the most expensive; in the following years, the shots are done monthly or even less frequently, resulting in lower costs. Charges can vary between $4,020 and $10,050 even before the visit, as vials need to be ordered before the immunotherapy begins. It is important that you call your insurance to make sure they cover these costs. For more information on these charges, please visit our web site: www.childrenshospital.org/allergyvisit

Will I get more than one bill for this visit?

If your health insurance company decides that you have a financial responsibility for this visit, you may get **two or more bills** for your child's visit at Boston Children's. ***Children's Hospital Physician Associates*** may send you a bill for the care provided by the doctor during your visit. ***Boston Children's Hospital*** may send you a bill which would cover services such as labs, x-rays, medications, diagnostic testing, use of equipment, and supplies. You may also get bills from other departments within the hospital if your child received care from these departments. For example, if your child had an x-ray, you may get a bill from the Department of Radiology and one from Children's Hospital Physician Associates.

If I have a question about my bill, who should I call?

Patient Accounting Representatives are available to assist you with your insurance, billing or financial questions. Please call 1-800-901-8089 with any questions.

Important Information Regarding Insurance Information for Skin and IgE Specific Allergen Blood Testing

Your child's doctor might recommend skin testing during your visit in order to identify his/her allergies. It is important to understand that this testing will generate a separate charge in addition to the clinic visit charge. This treatment charge may not be covered by your insurance company. The skin testing charge will most likely be covered by your insurance carrier if a referral has been authorized. You should, however, check with your insurance to make sure the skin testing is covered.

Each patient receiving skin testing is billed based upon how many allergens they are tested for. The number of allergens can range from three to sixty-four with the charges ranging from $129 to $3,432, varying from patient to patient. Your provider might also request that an IgE specific allergen blood test is done. This may be instead of or in addition to the skin testing. This is a blood test which also checks for allergies.

Your child will be billed for the following charges of skin testing and allergy blood testing. The actual amount may vary depending on any discounts negotiated by your insurance plan but is usually lower.

Procedure	Billing CPT Code	# per visit	Total Charge
Percutaneous test	95004	3 to 64	$43 per allergen tested*
Intracutaneous test	95024	1 to 10	$50 per allergen tested*
IgE Specific Allergen Blood Test	86003 or 86005	3 to 20	$34 per allergen tested*

***PLEASE NOTE: The number of allergens being tested is dependent upon each individual patient. Total charges usually vary between $129 and $3,432.**

Please call your insurance company to inquire about coverage/benefits under your plan and your required out of pocket payments. Coverage policies for individual carriers differ greatly. It is important to consult with your insurance company to see if these services will be covered under your individual plan.

Here are some important areas to understand about your benefits plan:

Prior Authorization:

Prior Authorizations are often required by insurance companies for specialty appointments. However, prior authorization is not a guarantee of payment if providers are considered out-of-network for your insurance company, or if the insurer decides at a later date that the services were not "medically necessary."

In Network and Out-of-Network:

The provider for this visit may be considered in-network or out-of-network. This can affect the amount you are required to pay. For information on which providers are within your network, please call your insurance company directly.

Medical Necessity:

Many insurance companies will determine coverage based on the diagnosis submitted on the claim. Your clinician submits the diagnosis they determine is the most appropriate. We cannot guarantee that your insurer will deem the service "necessary" based on that diagnosis.

Co-payments, Deductibles and Coinsurance:

In addition to co-payments, you may have an annual deductible payment and a co-insurance (which is a certain percentage of the bill) payment, depending on which plan you have through your insurance.

Please feel free to contact our billing office for any further questions or concerns at 1-844-769-7804 for the skin testing and 617-355-3397 for the IgE specific allergen blood test.

Boston Children's Hospital

LABEL OR PRINT
NAME

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ALLERGY/IMMUNOLOGY NEW PATIENT QUESTIONNAIRE

Name:	**Date of Birth:**
Pharmacy Name:	**Pharmacy Address:**
Specialty Pharmacy Name:	

I want to know:

My questions are:

I don't want to leave without this (asthma or epinephrine action plan, prescription, etc):

REVIEW OF SYSTEMS

Has your child been experiencing or diagnosed with any of the following?
Please check any that apply

General
- ☐ Feeling tired
- ☐ Fevers
- ☐ Chills or night sweats
- ☐ Poor weight gain
- ☐ Changes in appetite

Eyes
- ☐ Red or itchy eyes
- ☐ Blurred or altered vision
- ☐ Sensitivity to light

Ear/Nose/Throat
- ☐ Nasal congestion/snoring
- ☐ Post nasal drip/nasal discharge
- ☐ Ear or throat pain
- ☐ Nose bleeds
- ☐ Nasal polyps
- ☐ Loss of smell

Urinary
- ☐ Pain with urination
- ☐ Increased frequency of urination
- ☐ Urine infections

Lungs
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Heart
- ☐ Heart murmur
- ☐ Heart palpitations/irregular heartbeat
- ☐ Heart defects

Gastrointestinal
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Nausea/Vomiting
- ☐ Acid reflux/heartburn
- ☐ Blood in stool
- ☐ Enlarged liver or spleen

Blood
- ☐ Easy bruising or bleeding
- ☐ Swollen glands
- ☐ Anemia
- ☐ Low white blood cell/platelet counts

Endocrine
- ☐ Excessive thirst
- ☐ Hot or cold intolerance
- ☐ Thyroid disorders
- ☐ Diabetes
- ☐ Delayed puberty

Skin
- ☐ Rash
- ☐ Birth marks or large moles

Bones/joints
- ☐ Muscle pain
- ☐ Joint pain/swelling

Neurologic
- ☐ Headaches
- ☐ Dizziness or lightheadedness
- ☐ Weakness/numbness/tingling
- ☐ Seizures

Psychiatric
- ☐ Hyperactivity disorder
- ☐ Depression or anxiety
- ☐ Sleep disturbances

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ALLERGY/IMMUNOLOGY NEW PATIENT QUESTIONNAIRE

LABEL OR PRINT
NAME

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Has your child been diagnosed or suspected to have any of the following:

Asthma? ☐ **Yes** ☐ **No**
If yes: Has your child been hospitalized? ☐ Yes ☐ No
Has symptoms with exercise/activity? ☐ Yes ☐ No
Taken oral steroids? ☐ Yes ☐ No If yes, how often? _____

Eczema? ☐ **Yes** ☐ **No**
If yes: What skin moisturizers are used? _____
How often does your child bathe? _____
Difficulty sleeping due to itching? ☐ Yes ☐ No
Has your child had skin infections? ☐ Yes ☐ No

Nasal/Eye Allergies? ☐ **Yes** ☐ **No**
If yes: What symptoms? ☐ Sneezing ☐ Congestion ☐ Post-nasal drip ☐ Runny nose ☐ Red itchy eyes
Other symptoms: _____
What triggers your child's symptoms? _____
What seasons are worse? ☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ Always bad

Increased frequency/severity of infections? ☐ **Yes** ☐ **No**
If yes: What type of infections? ☐ Ear infections ☐ Sinus infections ☐ Pneumonias ☐ Bronchitis ☐ Other
How many courses of antibiotics has your child taken in the past 12 months? _____

Food allergies? ☐ **Yes** ☐ **No**
If yes, please list foods restricted: _____

Has your child had any other medical problems or diagnoses? _____
_____

Has your child been hospitalized or had any surgeries? If yes, please describe: _____
_____

List any medication allergies: _____

Are your child's immunizations up to date? ☐ **Yes** ☐ **No ; Did your child receive the influenza vaccine this year?** ☐ **Yes** ☐ **No**

FAMILY HISTORY: Please indicate if the patient's parents or siblings have had any of the following conditions:

	Asthma	Nasal/Eye Allergy	Eczema	Food Allergy	Drug Allergy	Immune Deficiency
Biological Mother						
Biological Father						
Child's Brothers and Sisters						

ENVIRONMENTAL HISTORY:

Does your child live in: ☐ An apartment ☐ A house ☐ A multifamily house/condo ☐ Other: _____
☐ Multiple home settings: _____

Do you have a basement? ☐ Yes ☐ No **If Yes:** Is it ☐ Finished ☐ Dry ☐ Damp ☐ Has flooded

Climate control: ☐ Hot water heat ☐ Steam heat ☐ Forced hot air ☐ Wood stove ☐ Space heater
☐ Central AC ☐ Window A/C ☐ Air filters ☐ Air cleaner/purifier
☐ Humidifier ☐ Dehumidifier ☐ Other: _____

Does your home have? ☐ Mold or mildew ☐ Damp or musty smell ☐ Water stains ☐ Mice ☐ Cockroaches ☐ None

Flooring: ☐ Hardwood ☐ Tile/linoleum ☐ Wall to wall carpeting ☐ Area rugs ☐ Other: _____

Exposure to pets? ☐ No ☐ Yes (If yes, please describe): _____

Do you or any of your child's caretakers smoke? ☐ No ☐ Yes

Does your child's bedroom have? ☐ Stuffed animals ☐ Rugs ☐ Carpeting ☐ Blinds ☐ Curtains
☐ Air conditioning ☐ Humidifier ☐ Feather pillow ☐ Down comforter
☐ Air cleaner/purifier ☐ Allergy-proof mattress or pillow covers

School, work, or day care environment (please describe): _____

Patient/Patient Representative Signature	Name (printed):	Relationship to patient or Patient	Time	Date