



Pediatric and Adult Allergy

Kristin Larson, PA-C MeeLee C. Nelson, M.D

3955 Parklawn Avenue * Suite 110 * Edina, MN 55435 * (952) 831-4454 ext. 4
501 E. Nicollet Boulevard * Suite 200 * Burnsville, MN 55337 * (952) 898-5900 ext. 4
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)
<u>Date of last shot:</u>	<u>Serum:</u>	<u>Concentration:</u>	<u>Dose:</u>	

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: _____