I M + P C

THE INTERNAL MEDICINE & PEDIATRIC CLINIC OF NEW ALBANY, PLLC

The Vaccine For Children Program is a program that pays for immunizations on children through 18 years of age who meet at least one of the following criteria:

- **Medicaid eligible:** A child who is eligible for the Medicaid program. (For the purposes of the VFC program, the terms "Medicaid-eligible" and "Medicaid-enrolled" are equivalent and refer to children who have health insurance covered by a state Medicaid program)
- **Uninsured:** A child who has no health insurance coverage
- **American Indian or Alaska Native:** As defined by the Indian Health Care Improvement Act (25 U.S.C. 1603)
- **Underinsured:** A child who has commercial (private) health insurance but the coverage does not include vaccines, a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only), or a child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured. Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

The Internal Medicine and Pediatric Clinic of New Albany, PLLC is a Federally Qualified Health Center Designee and participates in the VFC program. To stay in compliance with the VFC program, we cannot blindly file a patient's insurance to see if immunizations are covered and then transfer the charges over to VFC if they are not covered. WE MUST KNOW BEFORE THE IMMUNIZATIONS ARE GIVEN. It is the responsibility of the insured (parent/guarantor) to know prior to scheduling the immunizations whether they are covered by their insurance or not.

Most insurance companies cover well child checkups on children up to 2 years of age. However, not all companies cover this service or the coverage varies. It is the responsibility of the insured (parent/guardian) to call their insurance prior to scheduling the visit to find out what is covered and at what rate. The Internal Medicine and Pediatric Clinic of New Albany does try to call and verify coverage the day before your child's appointment. We do not, however, cancel your appointment or reschedule your appointment if you do not have coverage. You will be notified of our findings when you arrive for the appointment. If you do not have well child coverage you will be asked to pay up front for this service. Therefore, it is to your benefit to call your insurance company yourself and know your coverage prior to making the appointment, so that you will be prepared to pay. If you are unable to pay for the service on the scheduled appointment date you will be asked to reschedule until such time payment can be made.

I, the undersigned, understand and agree that it is my responsibility to contact my insurance carrier prior to scheduling all well child checkups and immunizations to verify my benefits for these services. I understand that these are services that may be repeated several times over the course of my son's/daughter's childhood and that I will need to contact my insurance carrier for updated benefits prior to each scheduled visit. I am aware that failure to do so could result in non-covered services that I will be financially responsible for. I further agree that I am responsible for all coinsurance, copays and deductibles that my insurance carrier may apply to these services and failure to pay will result in being sent to an outside collection agency and termination as a patient from The Internal Medicine and Pediatric Clinic of New Albany, PLLC.

I, the undersigned, understand and agree that if my child qualifies for the VFC program that I am still financially responsible for the administration fee for each immunization given, which is $10.00 per immunization.

Responsible Party Signature _____ Date _____

Patient's Name _____ Date _____