

## **FLUMIST<sup>®</sup> ACKNOWLEDGEMENT FORM**

I \_\_\_\_\_, have been informed that my health care benefits insurer or administrator, BlueCross BlueShield of Tennessee, Inc. (BCBST), has determined that *FluMist<sup>®</sup>* (CPT<sup>™</sup> Code 90660) may be an eligible expense under the terms of my health care benefits plan, but the reimbursement made by BlueCross BlueShield of Tennessee for *FluMist<sup>®</sup>* will not cover the entire cost of the service.

I have been informed about the potential costs of the referenced services. I understand that I will be responsible for all charges that exceed the Maximum Allowable Charge that may be available under the terms of my health benefits plan, if I elect to receive those services.

Signature of Patient or Responsible  
Person

\_\_\_\_\_

Date: \_\_\_\_\_