TAX ID 54-1850988

# Paragard, Mirena, Kyleena & Nexplanon

## Coverage Worksheet

## **Please bring this completed form with you to your appointment for insertion**

Prior to scheduling your appointment, we kindly advise contacting your insurance company to verify coverage for the specific medical device you wish to have implanted. Please ensure that the procedure codes for both the device and insertion are confirmed as covered medical benefits under your insurance policy. This proactive step will help prevent any potential billing issues and ensure a smooth process for your healthcare needs. Should you require any assistance or further information, please do not hesitate to contact our office. The procedure codes for reference are listed below:

| Name | Procedure Code | Charge |
|---|---|---|
| Insert of IUD | 58300 | $797 |
| Paragard IUD | J7300 | $2,062 |
| Mirena IUD | J7298 | $2,318 |
| Kyleena IUD | J7296 | $2,318 |
| Insert of Nexplanon | 11981 | $500 |
| Nexplanon Implant | J7307. | $2,835 |
| While not all patients may necessitate ultrasound guidance for IUD insertions, we recommend verifying your insurance benefits to confirm coverage for both the device and insertion, as well as for associated sonogram codes, including transabdominal, transvaginal, and ultrasound guidance. | | |
| Transabdominal | 76856 | $585 |
| Transvaginal Ultrasound | 76830 | $669 |
| Ultrasound Guidance | 76998 | $450 |

Date: _____

Person you spoke with: _____

Insertion covered at what percentage of contracted rate? _____

IUD/Nexplanon covered as a Medical Benefit @what percentage? _____

Do I have a copay with the visit? _____

**Self-pay Patients**- We kindly request that self-pay patients contact our office to speak with a team member regarding pricing for hormonal device insertions. Our dedicated staff is committed to providing comprehensive assistance and ensuring transparency in financial matters. By engaging with our team, patients can receive personalized information tailored to their specific needs, enabling them to make informed decisions about their healthcare.

I understand, I am responsible for any payment denied or not covered by my insurance company if, I elect to proceed with the ordering and insertion of the device.

Name: _____

Date of Birth: _____

Signature _____ Date: _____

Revised 5/15/24