Serogroup B Meningococcal (MenB) Vaccine Advance Beneficiary Notice Reimbursement Waiver
SouthPark Pediatrics, PA

Name _____ DOB_____ Chart Number _____

The American Academy of Pediatrics and the Centers for Disease Control are recommending routine vaccination of adolescents age 16 through 23 years with the **Serogroup B Meningococcal (MenB)** vaccine to provide protection against meningococcal disease caused by serogroup B.

Your health insurance company might not cover expenses for this important vaccine for adolescents. The total cost for this 2-dose series vaccine and its administration is **$284.70**.

___I agree to the immunization of my child with **Serogroup B Meningococcal (MenB)** and will pay for this "not covered by insurance" vaccine and service. I understand that in order to achieve reported efficacy for protection from this bacteria, the **TWO DOSE REGIMEN IS REQUIRED**, and that cost is established based on cost of purchase price as a baseline, required storage and maintenance standards for vaccine effectiveness, and administration of this 2 dose series vaccine.

___I have reviewed the vaccine information sheet and had the opportunity to discuss concerns with the doctor and I decline immunization of my child with **Serogroup B Meningococcal (MenB)**.

___ I have reviewed the information sheet and had the opportunity to discuss concerns with the doctor and will check with my child's Mom___ or Dad___.

_____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature

_____ _____
Witness Date