Service/Fee Request Form											
Union County Human Services Agency Division of Public Health											
CPT Code/ Program	**Program Description**	**Fee Slide Y or N**	**Recommended Fee By Department**	**Medicaid (MCD) Reimbursement**	**Commercial Reimbursement**	**New Program Y/N**	**Existing Fee Y/N**	**Reason for Adjustment**	**Requested By**	**Effective Date**	**Financial Impact**
90710- MMRV	IM	N	$347.30	$267.15	$307.40	N	N	New fee request	Immunization	Upon Human Service Board and BOCC Approval	The addition of this fee will help increase Public Health revenue and offset the cost of providing associated clinical services.
						N					
						N					
Approved By:_____ Date:_____											
Approved By:_____ Date:_____											