2020-2021 Flu Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine *(please print):* **Required Fields*

Name: (Last, First, MI) *	Date of birth: * _____ ____ _____ Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address: *			
City: *	State: *	Zip: *	Phone: * ( )

For children 18 years of age and younger:

Is Vaccine for Children (VFC) Program eligible:
- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:
- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company: *	Member ID Number: *	Group ID Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

If person getting vaccinated is not the insurance subscriber/policy holder, please complete the following:

Subscriber's Name: (Last, First, MI) *	Subscriber's Date of Birth: * _____ ____ _____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address: * (If different from address above)		
City: *	State: *	Zip: *	Phone: * ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I have been given a copy and have read, or had explained to me, the Vaccine Information Statement for the Seasonal Influenza Vaccine and understand the risks and benefits. I understand that children younger than 9 years of age may need 2 doses of vaccine. I voluntarily give consent for the person named above to be vaccinated. I give permission to bill my/his/her health insurance.

X _____ Date: _____
(Signature of patient, parent or legal guardian)

For Clinic/Office Use Only:

Date of Service/Date VIS Given	Date on VIS	Vax Type	Vaccine Manufacturer	Lot Number & Exp Date	State Supplied (Circle)	Preservative Free* (Circle)	Dose (mL)	Injection Route	Injection Site (Circle)
	08/15/19				Yes No	Yes No	0.5 0.7	IM	R Arm L Arm R Leg L Leg

Signature of Vaccine Administrator:_____

Provider Name/Address: Nashoba Associated Boards of Health, 30 Central Avenue, Ayer, MA 01432 MDPH Provider PIN#: 11194

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***Place Photo Copy of All Insurance Cards Here:**