2020-2021 Flu and Pneumo 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.

Example

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

Name: (Last, First, MI)*	Date of birth: *	Age	Sex: (Circle)
SMITH, JOHN C.	6 / 5 / 1950 (Month Day Year)	70	(Male) Female
Street Address:* 12 Oak Street			
City:* CARLISLE	State:* MA	Zip:* 01741	Phone:* (781 843-2112

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		
Medicare Number: 1HT3467SL9	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: *	Sex: (Circle)*
	Month Day Year	Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:* / Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

SIGN BELOW

I give permission for my insurance company to be billed.

(X) John Smith (Signature of patient, parent or legal guardian) Date: 9.9.2020

For Clinic/Office Use Only:

Signature of Vaccine Administrator: _____

Date of Service	Vax Type	Vaccine Mfgr	State Supplied (Circle)	Preserv Free*	Lot No	Exp Date	Dose (mL)	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
10-2-2020	IIV4 Quadrivalent Influenza		Yes No	Yes No			0.25 0.5	IM	R Arm L Arm R Leg L Leg	8-15-19	
10-2-2020	Fluzone High Dose (HD-IIV4)	Sanofi Pasteur	No	Yes			0.7	IM	R Arm L Arm	8-15-19	

Provider Name: Emerson Hospital Home Care MDPH Provider PIN#: 22135

Provider Address: 310 Baker ave Concord MA 01773