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:* ( )

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 give permission for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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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
	IIV4		Yes No	Yes No			0.25 0.5	IM	R Arm L Arm R Leg L Leg		
	Fluzone High Dose (IIV3-HD)	Sanofi Pasteur	No	Yes			0.5	IM	R Arm L Arm		

Provider Name: **Town of Scituate/Board of Health** MDPH Provider PIN#: **11528**

Provider Address: **600 Chief Justice Cushing Highway, Scituate, MA 02066**