2018-2019 Insurance Information Form for Flu Vaccine

If no insurance information is available, please fill out as much information as possible. Form is necessary for each vaccine recipient.

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:* ( )

If person getting vaccinated is NOT the subscriber; 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:* (**Only if different from address above**)			
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other			

Insurance Information: *Include 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

By signing below, I give my permission for my insurance company to be billed for this service.

Signature: X ________________________________ **Date:** ________________

(Signature of patient, parent or legal guardian)

For Children 18 years of age and under check which of the following applies;

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**

Signature of Vaccine Administrator: ______________________

Date of Service	Vax Type	Vaccine Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route	Injection Site Deltoid (Circle)	Date On VIS	Date VIS Given
10/20/18	Fluzone IV	Sanofi	UT6262KA	6/30/19	0.5	N	Y	IM	R L	8/7/15	10/20/18

Provider: Westwood Board of Health MDPH Provider Pin #: 11764

Provider Address: 50 Carby Street Westwood, MA 02090 Provider Phone: 781-320-1027