2019-2020 Flu Insurance Information Form PRINT CLEARLY

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)

For Clinic/Office Use Only

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

Date of Service & VIS Given	Vax Type	Vaccine Mfgr	State Supplied (Circle)	Preserv Free*	Lot No	Exp Date	Dose (mL)	Injection Route (Circle)	Injection Site (Circle)	Date On VIS
	IIV4 / QIV State Supply	Flulaval GSK	Yes	Yes	95RZ3	06/05/2020	0.5	IM	R L Arm	08152019
	IIV4 / QIV Multi-dose vial	Sanofi Fluzone	No	No	UJ223AA UJ269AA	06/30/2020	0.5	IM	R L Arm	08152019
	IIV4 / QIV Prefilled / Preservative Free	Sanofi Fluzone	No	Yes	UT6654KA UT6657KA	06/30/2020	0.5	IM	R L Arm	08152019
	Fluzone High Dose (IIV3-HD)	Sanofi Pasteur	No	Yes	UJ242AA UJ281AB	05/04/2020 5/16/2020	0.5	IM	R L Arm	08152019

Signature of Vaccine Administrator: ____

Provider Name: Framingham Health Department MDPH Provider PIN#: 10510 Provider Address: 150 Concord Street Framingham, MA 01702