2020-2021 Flu and Pneumo Insurance Information Form

The completed 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. I give permission for my child to be vaccinated.

X ____ Date: __________________

(Signature of patient, parent or legal guardian)

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For children 18 years of age and younger: *☐Is Vaccine for Children (VFC) Program eligible: ☐ is enrolled in Medicaid ☐ does not have health insurance or ☐Is American Indian (Native American) or Alaska Native ☐Is not VFC-eligible: Has health insurance & is not Native American Indian or Alaska Native*

Date of Service Date 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 Fluzone	Sanofi Pasteur	No	No	UJ452AB UJ476AA	6/30/2021	0.5	IM	R L Arm Leg	8/15/2019
	Fluzone High Dose (HD-IIV4) QIV	Sanofi Pasteur	No	Yes	UJ461AB UJ480AA	6/30/2021	0.7	IM	R L Arm	8/15/2019
	Flulaval	GlaxoSmithKline	Yes	Yes	2SM24	6/30/2021	0.5	IM	R L Arm Leg	8/15/2019

Signature of Vaccine Administrator: ____

Provider Name: Framingham Board of Health MDPH Provider PIN#: 10510 Provider Address: Concord St. Framingham, MA 01702