2015-2016 Influenza Insurance 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 Employed? Yes No

If person getting vaccinated is not the subscriber, 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: 10/8/2015

(Signature of patient, parent or legal guardian)

For Clinic/Office Use Only:

Signature of Vaccine Administrator:_____

Date of Service	Vax Type	Vax Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS given
10/8/15	IIV4	Sanofi			0.5	No	No	IM	R Arm L Arm	8/7/15	10/8/15
	IIV Hi Dose	Sanofi			0.5	No	Yes	IM	R Arm L Arm		

Provider Name: Sudbury Board of Health MDPH Provider PIN#: 33333

Provider Address: 275 Old Lancaster Road Sudbury MA. 01776