2020-2021 Adult Flu Insurance Information & Consent 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)

For Official Use Only:

Date of Service	Vax Type	Vaccine Mfgr	State Supplied	Preserv Free*	Lot No	Exp Date	Dose (mL)	Injection Route	Injection Site (Circle)	Date On VIS	Date VIS Given
	Fluzone High Dose (IIV4-HD)	Sanofi Pasteur	No	Yes	UJ453AA	6/30/2021	0.7	IM	RA LA	8/15/2019	
	Flublok (RIV4)	Sanofi Pasteur	No	Yes	QFAA2010	6/30/2021	0.5	IM	RA LA	8/15/2019	

Signature of Vaccine Administrator: _____

Provider Name: **SANDWICH PUBLIC HEALTH NURSING DEPARTMENT** MDPH Provider PIN#: **11519**

Provider Address: **270 QUAKER MEETINGHOUSE ROAD, EAST SANDWICH, MA 02537**