2018-2019 Flu Vaccine Insurance Information 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. **A copy of your insurance card will be taken at the clinic.**

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)

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***Place Photo Copy of All Insurance Cards Here:**

Provider Name: _Marlborough Board of Health_____ MDPH Provider PIN#: _____

Provider Address: _____140 Main Street, Lower Level, Marlborough, MA, 01752_____

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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

Is not VFC-eligible:

- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

**********Do Not Write Below this Line**********
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For Clinic/Office Use Only:

Date of Service	Vax Type	Vaccine Mfgr	State Supplied (Circle)	Preserv Free*	Lot No	Exp Date	Dose (mL)	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV4	Sanofi Pasteur	Yes No	Yes No			0.25 0.5	IM	R Arm L Arm R Leg L Leg	08/07/2015	
	Fluzone High Dose (IIV3-HD)	Sanofi Pasteur	No	Yes			0.5	IM	R Arm L Arm	08/07/2015	
	Flublok (RIV4)	Sanofi Pasteur	No	Yes			0.5	IM	R Arm L Arm	08/07/2015	

Signature of Vaccine Administrator: _____

Printed Name of Vaccine Administrator: _____

Provider Name: _Marlborough Board of Health_____ MDPH Provider PIN#: _____

Provider Address: _____140 Main Street, Lower Level, Marlborough, MA, 01752_____