# 2017-2018 Flu 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.

**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 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: _____

(Signature of patient, parent or legal guardian)

**********

**For Clinic/Office Use Only:** ***Place Photo Copy of All Insurance Cards Here:***

Provider Name: Town of Greenfield Health Department MDPH Provider PIN#: 14915

Provider Address: 20 Sanderson Street, 14 Court Square (mailing address), Greenfield, MA 01301 (413) 772-1404 x2102

# 2017-2018 Flu Insurance Information Form

**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

**Signature of Vaccine Administrator:** _____

| Date of Service | Vax Type | Vaccine Mfgr | Lot No | Exp Date | Dose (mL) | State Supplied (Circle) | Injection Route (Circle) | Injection Site (Circle) | Date On VIS | Date VIS Given |
|---|---|---|---|---|---|---|---|---|---|---|
| | IIV4 | Sanofi Pasteur | | 30JUN18 | 0.25<br>0.5 | Yes<br>No | IM | R Arm L Arm<br>R Leg L Leg | 8/7/2015 | |

Name: _____ DOB: _____

Address:

_____

Provider Name: Town of Greenfield Health Department MDPH Provider PIN#: 14915

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