2020-2021 Flu Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance 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.

_____I attest I have no COVID-19 symptoms today: cough, sore throat, etc. Temperature: _____

X _____ Date: _____
(Signature of patient, parent or legal guardian)

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PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. **Is the person to be vaccinated sick today?** **Yes___ No____**
2. **Have you ever had the Flu Vaccine Before?** **Yes___ No____**
3. **Have you ever had a serious reaction to Flu Vaccine in the past?** **Yes___ No____**
4. **Do you have an allergy to Eggs, Gentamicin, Neomycin, Polymixin, Gelatin or other components of the vaccine** **Yes___ No____**
5. **Have you ever had Guillian-Barre Syndrome?** **Yes___ No____**

Provider Name: WRENTHAM BOH MDPH Provider PIN#: 11822

Provider Address: 79 South St., Wrentham, MA 02093