2010 - 2011 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)

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)

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For Clinic/Office Use Only:

Date vax given:	Seasonal Flu Vax Type	Vax Manufacturer	Vax Exp. Date & Lot No.	Dose No.	Preserv. Free	Injection Site & Route: (Circle)*	Date on VIS	Date VIS Given
	TIV LAIV	Novartis MedImmune FluMist	111784P1 Exp. 3/31/11 501043P, Exp. 1/9/11	1 2 Amount:	Yes No	Intranasal IM R Arm L Arm R Leg L Leg	8/10/10	

Clinic Site Name: Westminster Board of Health MDPH Provider PIN#: 14838

Clinic Address: 11 South Street, Westminster, MA 01473

Signature of Vaccine Administrator: _____ Date: _____

Use the space below to record any additional information: (optional)

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