2020-2021 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. ***QUESTONS ON BACK>>>>>>>**

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: _____Billerica Board of Health______ MDPH Provider PIN#: _10151__

Provider Address: __365 Boston Road Billerica, MA 01821____ **Nurse: Initial/Sig/Date.:**______________________

2020-2021 Flu Insurance Information Form

Vaccine Screening Questions : (questions will be reviewed on the day of service)

Has this person to be vaccinated ever receive a flu vaccine?	Yes	No
Did you answer yes to any of the COVID-19 ENTRANCE QUESTONS?	Yes	No
Is this person to be vaccinated running a fever or feeling ill today?	Yes	No
Is this person to be vaccinated allergic to eggs, latex, or thimerosal?	Yes	No
Has the person to be vaccinated ever had Guillain-Barre Syndrome?	Yes	No
Has the person to be vaccinated ever had a serious reaction to a flu vaccine?	Yes	No

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

For Clinic/Office Use Only:

Signature of Vaccine Administrator: ____

Date of Service (Circle)	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
10/14/2020 10/17/2020	IIV4 Fluzone Multi dose	Sanofi Pasteur	Yes No	Yes No	UJ475AB UJ476AA	30Jun21	0.25 0.5	IM	R Arm L Arm R Leg L Leg	8/15/19	
10/14/2020 10/17/2020	IIV4 Fluzone Prefilled syringes	Sanofi Pasteur	No	Yes	UT7000CA	30Jun21	0.5	IM	R Arm L Arm R Leg L Leg	8/15/19	
10/14/2020 10/17/2020	Fluzone High Dose (HD-IIV4)	Sanofi Pasteur	No	Yes	UJ490AA UJ460AA	30Jun21 30Jun21	0.7	IM	R Arm L Arm	8/15/19	

Provider Name: _____**Billerica Board of Health**_______ **MDPH Provider PIN#:** _**10151**__

Provider Address: __**365 Boston Road Billerica, MA 01821**____ **Nurse: Initial/Sig/Date.:**________________________