2017-2018 Flu Insurance Information Form

LYNNFIELD HEALTH DEPARTMENT

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)

****

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

Provider Name: Lynnfield Board of Health MDPH Provider PIN#: 11005

Provider Address: 55 Summer Street, Lynnfield, Ma. 01940

2017-2018 Flu Insurance Information Form

LYNNFIELD HEALTH DEPARTMENT

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	Vax Type	Vaccine Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied (Circle)	Preserv Free*	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV4				0.25 0.5	Yes No	Yes No	IM	R Arm L Arm R Leg L Leg		
	Flucelvax (ccIIV4)	Seqirus			0.5	Yes	Yes	IM	R Arm L Arm		
	IIV3				0.5	No	Yes No	IM	R Arm L Arm R Leg L Leg		
	Fluzone High Dose (IIV3-HD)	Sanofi Pasteur			0.5	No	Yes	IM	R Arm L Arm		
	IIV4	Sanofi Pasteur	UT5899LA	06/30/18	0.5	No	Yes	IM	R Arm L Arm		
	Flublok (RIV3)	Protein Sciences			0.5	No	Yes	IM	R Arm L Arm		
	Flublok (RIV4)	Protein Sciences			0.5	No	Yes	IM	R Arm L Arm		
	PCV13	Pfizer			0.5	No	Yes	IM	R Arm L Arm		
	PPSV23	Merck			0.5	Yes No	Yes	IM SC			

Provider Name: Lynnfield Board of Health MDPH Provider PIN#: 11005

Provider Address: 55 Summer Street, Lynnfield, Ma. 01940