

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: *	Age	Sex: (Circle)					
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">Month</td> <td style="width: 33%; text-align: center;">Day</td> <td style="width: 33%; text-align: center;">Year</td> </tr> </table>	Month	Day	Year		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Male</td> <td style="width: 50%; text-align: center;">Female</td> </tr> </table>	Male	Female
Month	Day	Year						
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)
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If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)	Subscriber's Date of Birth:	Sex: (Circle)					
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">Month</td> <td style="width: 33%; text-align: center;">Day</td> <td style="width: 33%; text-align: center;">Year</td> </tr> </table>	Month	Day	Year	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Male</td> <td style="width: 50%; text-align: center;">Female</td> </tr> </table>	Male	Female
Month	Day	Year					
Male	Female						
Subscriber's Street Address: <i>(if different from address above)</i>							
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:

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
				1	2		Intranasal	IM		
	TIV					Yes				
	LAIV			Amount:		No	R Arm	L Arm		
							R Leg	L Leg		

Clinic Site Name: _____ MDPH Provider PIN#: _____

Clinic Address: _____

Signature of Vaccine Administrator: _____ Date: _____

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