2020 - 2021 Insurance and Consent Information Form – Flu and Pneumonia

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible

Information about the person to receive vaccine Please Print Legibly – Do Not Use Nicknames **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 # (if available):
Medicare Number (if applicable):	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		

For children 18 years of age and younger – Parent or Guardian please complete:

____ 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
____ Has health insurance and is not Native American or Alaska Native

I give permission to receive vaccine and for my insurance company to be billed.

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

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	Sanofi			0.5	No	No	IM	R Arm L Arm	8/15/19	
	Flulaval	GSK			0.5	Yes	Yes	IM	R Arm L Arm	8/15/19	
	High Dose	Sanofi			0.7	No	Yes	IM	R Arm L Arm	8/15/19	
	LAIV4	AstraZeneca			0.2	Yes	Yes	Intranasal	N/A	8/15/19	
	Flublok RIV4	Sanofi			0.5	No	Yes	IM	R Arm L Arm	8/15/19	

Provider and Address: Andover Health Dept., 36 Bartlet Street, Andover MA 01810 **MDPH Pin: 10049**