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.

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)

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

Provider Name: Dedham Health Department MDPH Provider PIN#: 10349

Provider Address: 450 Washington Street, Dedham MA 02026

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For Clinic/Office Use Only:

Date of Service	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
	IIV4 Fluzone	Sanofi Pasteur	Yes	Yes	UT7035JA	6/21	0.5	IM	R Arm L Arm	8/15/2019	
	Flucelvax (ccIIV4)	Seqirus	No	Yes	276575	6/21	0.5	IM	R Arm L Arm	8/15/2019	
	Fluad quadrivalent (aIIV4)	Seqirus	No	Yes	279812	6/21	0.5	IM	R Arm L Arm	8/15/2019	
	Fluad quadrivalent (aIIV4)	Seqirus	No	Yes	279795	6/21	0.5	IM	R Arm L Arm	8/15/2019	
	IIV4 Flulaval	GSK	No	Yes	ZK9TH	6/21	0.5	IM	R Arm L Arm	8/15/2019	
	Flucelvax (ccIIV4)	Seqirus	No	Yes	279839	6/21	0.5	IM	R Arm L Arm	8/15/2019	
	IIV4 Flulaval	GSK	Yes	Yes	42DT9	6/21	0.5	IM	R Arm L Arm	8/15/2019	

Signature of Vaccine Administrator: _____

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