2020-2021 Adult Vaccine 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)

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 Clinic/Office Use Only: PLACE CARD COPY BELOW

Provider Name: Spfld. Health & Human Services Dept. MDPH Provider PIN#: 11854

Provider Address: 311 State St., Spfld., MA 01105

Signature of Vaccine Administrator: _____

2020-2021 Adult Vaccine Insurance Information Form

Please note: influenza and pneumococcal vaccines are recorded on a separate form.

Vaccine	Type of Vaccine*	Date of Service	Dose	Route (PO, SC, IM, ID, IN, MP)	Site (RA,LA, RT, LT)	Vaccine		Vaccine Information Statement	
						lot #	mfr.	Date on VIS	Date Given
Tetanus, Diphtheria, Pertussis (Tdap*, Td*)				IM					
Varicella (Var)				SC					
Measles, Mumps, Rubella (MMR)				SC					
Human Papillomavirus 9-valent (9vHPV)*				IM					
Zoster (Shingles) Shingrix (RZV) Zostavax (ZVL)				IM SC					
Meningococcal Quadrivalent (ACWY) Menactra (MenACWY-D)* Menveo (MenACWY-CRM)*				IM					
Meningococcal Serogroup B (MenB) Bexsero (MenB-4C)* Trumenba (MenB-FHbp)*				IM					
Hepatitis A (HepA)				IM					
Hepatitis B (HepB) (HepB-CpG)				IM					
Hepatitis A-Hepatitis B (HepA-HepB**)**				IM					
***Haemophilus influenzae* type B** (Hib)				IM					

Provider Name: Spfld. Health & Human Services Dept. MDPH Provider PIN#: 11854

Provider Address: 311 State St., Spfld., MA 01105