2015-2016 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 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: October 29, 2015

(Signature of patient, parent or legal guardian)

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

For children 18 years of age and younger:

Provider Name: **Westminster Board of Health** MDPH Provider PIN#: **14838**

Provider Address: **11 South Street, Westminster, MA 01473**

2015-2016 Insurance Information Form

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
	IIV3				0.25 0.5	No	Yes No	IM	R Arm L Arm R Leg L Leg		
	ccIIV3	Novartis			0.5	No	Yes	IM	R Arm L Arm		
	IIV4 Intradermal	Sanofi Pasteur			0.1	No	Yes	Intradermal	R Arm L Arm		
	IIV3 High Dose	Sanofi Pasteur			0.5	No	Yes	IM	R Arm L Arm		
Oct. 29, 2015	IIV4	Sanofi Pasteur	**UI440AE UI440AD UI431AD**	**June 30, 2015**	0.25 0.5	Yes No	Yes No	IM	R Arm L Arm R Leg L Leg		**Oct. 29, 2015**
	RIV3	Protein Sciences			0.5	No	Yes	IM	R Arm L Arm		
Oct. 29, 2015	LAIV4 **FLU MIST**	Med-Immune	**FJ2073**	**Dec.30, 2015**	0.2	**Yes** No	Yes	**Intranasal**	NA		**Oct. 29, 2015**
	PCV13	Pfizer			0.5	No	Yes	IM	R Arm L Arm		
	PPV23	Merck			0.5	Yes No	N/A	IM SC	R Arm L Arm		

IIV3 = Inactivated influenza vaccine, trivalent
ccIIV3 = Cell culture-based inactivated influenza vaccine
IIV4 intradermal = Inactivated influenza vaccine, quadrivalent, intradermal
IIV3 High Dose = Inactivated influenza vaccine, trivalent, high dose

IIV4 = Inactivated influenza vaccine, quadrivalent
RIV3 = Recombinant influenza vaccine, trivalent
LAIV4 = Live, attenuated influenza vaccine, quadrivalent
PPV23 = Pneumococcal polysaccharide vaccine, 23-valent
PCV13 =Pneumococcal conjugate vaccine, 13-valent

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